

95 21501

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) JOHN GREENWAY Sr. | | | | 2. DATE OF DEATH MONTH JULY DAY 12 YEAR 95 | | 3. TIME OF DEATH 5:10 A M | |
| 4. SOCIAL SECURITY NUMBER 212-58-7107 | | 5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 81 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) March 14, 1914 | |
| 9a. FACILITY NAME (If not institution, give street and number) St Agnes Hospital | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Baltimore | | 9c. COUNTY OF DEATH NA | |
| 10a. STATE Md | | | | 10b. COUNTY NA | | 10c. CITY, TOWN OR LOCATION Baltimore | |
| 10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | | | | | | |
| 10e. STREET AND NUMBER 5901 Doverdale Dr. | | | | 10f. ZIP CODE 21215 | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A | |
| 11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: Black | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 9th grade College (1-4 or 5+) NA | | 15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Tree Cutter | | 15b. KIND OF BUSINESS/INDUSTRY Forest | | | |
| 17. FATHER'S NAME (First, Middle, Last) James Greenway | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Carrie Harris | | | |
| 19a. INFORMANT'S NAME (Type/Print) Monica Melton | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5901 Doverdale Dr. #2 Baltimore, Md 21215 | | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Bing Memorial Park 7/12/95 | | 20c. LOCATION — City or Town, State Randallstown, Md | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Portia Ebron | | | | 22. NAME AND ADDRESS OF FACILITY March F.H. West 4300 Wabash Ave Baltimore, Md 21215 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | | a. CONGESTIVE HEART FAILURE | | | | | Approximate interval Between Onset and Death 2 wks |
| | | b. RENAL FAILURE | | | | | 5+ YRS |
| Sequitely ill conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | c. DUE TO (OR AS A CONSEQUENCE OF): | | | | | |
| | | d. DUE TO (OR AS A CONSEQUENCE OF): | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/> | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| | | 28d. DESCRIBE NOW INJURY OCCURRED | | | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | |
| | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | |
| 29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER Wadha Kar MEDICAL RESIDENT | | | | 29c. LICENSE NUMBER 2071 | | 29d. DATE SIGNED (Month, Day, Year) 7/12/95 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) DR. WADHA KAR ST AGNES HOSPITAL BALTIMORE, MD | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JUL 17 1995 | | | | 32. REGISTRAR'S SIGNATURE John Buckner Randall | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 21502

FilmG, 725, item #1,10e, 7/17/95,cyw

1 - STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|---|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) SHERIDAN PHILLIP GORMAN | | | | 2. DATE OF DEATH MONTH DAY YEAR JULY 9, 1995 | | 3. TIME OF DEATH 12:15 p.m. | |
| 4. SOCIAL SECURITY NUMBER 223-16-7570 | | 5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 87 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) May 28, 1908 | |
| 8. BIRTHPLACE (State or Foreign Country) Illinois | | | | 9a. FACILITY NAME (If not institution, give street and number) THE JOHNS HOPKINS HOSPITAL | | 9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE CITY | |
| 9c. COUNTY OF DEATH N/A | | | | 10a. STATE Maryland | | 10b. COUNTY N/A | |
| 10c. CITY, TOWN OR LOCATION Baltimore | | | | 10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 10e. STREET AND NUMBER 3427 University Parkway Place | |
| 10f. ZIP CODE 21218 | | | | 10g. CITIZEN OF WHAT COUNTRY? USA | | 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 4 | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Executive | | 16b. KIND OF BUSINESS/INDUSTRY Finance | |
| 17. FATHER'S NAME (First, Middle, Last) Bernard Peter Gorman | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Alice Dempsey | | | |
| 19a. INFORMANT'S NAME (Type/Print) Marie A. Newsom | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 26645 Altamont Road Los Altos Hills California 94022 | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Druid Ridge Cemetery 7/12 | | 20c. LOCATION — City or Town, State Pikesville, Maryland | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Donnis Stephen Kenner</i> | | | | 22. NAME AND ADDRESS OF FACILITY Mitchell-Wiedefeld Home 6500 York Road Baltimore, Maryland 21212 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Hypoxemia DUE TO (OR AS A CONSEQUENCE OF): b. pulmonary edema DUE TO (OR AS A CONSEQUENCE OF): c. Coronary Artery Disease DUE TO (OR AS A CONSEQUENCE OF): d. Approximate interval Between Onset and Death 12 hrs 2 day 20 yrs Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Aspiration pneumonia Colon Cancer Prostate cancer DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide 3 <input type="checkbox"/> Homicide 4 <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | 28g. DATE SIGNED (Month, Day, Year) July 11 1995 | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER <i>Donnis Stephen Kenner</i> | | | | 29c. LICENSE NUMBER M0220 | | 29d. DATE SIGNED (Month, Day, Year) July 11 1995 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) DAN GARCIA TOWER 110 JHA 600 N. WOLFE ST | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JUL 17 1995 | | 32. REGISTRAR'S SIGNATURE <i>Li. Andrew Randall</i> | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) <i>Inez Harris</i> | | | | 2. DATE OF DEATH MONTH <i>July</i> DAY <i>13</i> YEAR <i>95</i> | | 3. TIME OF DEATH <i>3:00 AM</i> | |
| 4. SOCIAL SECURITY NUMBER <i>214 983-2375</i> | | 5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) <i>85</i> YRS. | | 7. DATE OF BIRTH (Month, Day, Year) <i>Jan 30, 1910</i> | |
| 8a. FACILITY NAME (If not institution, give street and number) <i>St. Annes Hospital</i> | | | | 8b. CITY/TOWN OR LOCATION OF DEATH <i>Balto</i> | | 8c. COUNTY OF DEATH <i>N/A</i> | |
| RESIDENCE OF DECEDENT | | | | | | | |
| 10a. STATE <i>md</i> | | 10b. COUNTY <i>N/A</i> | | 10c. CITY/TOWN OR LOCATION <i>Balto</i> | | 10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | |
| 10e. STREET AND NUMBER <i>2585 W. Fayette st.</i> | | | | 10f. ZIP CODE <i>21223</i> | | 10g. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i> | |
| 11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: <i>Black</i> | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <i>9th</i> College (13-16 or 5+) <i>N/A</i> | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <i>Laundry Attendant</i> | | 16b. KIND OF BUSINESS/INDUSTRY <i>Laundry</i> | |
| 17. FATHER'S NAME (First, Middle, Last) <i>Esther Nathaniel Burrow</i> | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) <i>Maggie Harrison</i> | | | |
| 19a. INFORMANT'S NAME (Type/Print) <i>Esther Gee</i> | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>144 Willard St. Balto, md</i> | | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <i>Western Star Cem 7/17/95</i> | | 20c. LOCATION — City or Town, State <i>Catonsville, md</i> | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Thome A. Thompson</i> | | | | 22. NAME AND ADDRESS OF FACILITY <i>March F/H 4300 WABASH Ave</i> | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Valvular dysfunction</i> | | | | | | | |
| DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| b. <i>Acute myocardial infarction</i> | | | | | | | |
| DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| c. | | | | | | | |
| DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| d. | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | | | | |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | | | | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY <i>M</i> | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 28d. DESCRIBE NOW INJURY OCCURRED | | | | 28e. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER <i>Jeffrey Sully</i> | | | | 29c. LICENSE NUMBER <i>P07540</i> | | 29d. DATE SIGNED (Month, Day, Year) <i>July 13, 1995</i> | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>Jeffrey Sully 900 caton Avenue Baltimore MD</i> | | | | | | | |
| 31. DATE FILED (Month, Day, Year) <i>JUL 17 1995</i> | | | | 32. REGISTRAR'S SIGNATURE <i>Jebia Davidson-Randall</i> | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.


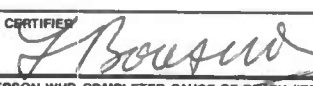
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 21504

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) Sister Mary Leonardine Hoover | | | | 2. DATE OF DEATH MONTH DAY YEAR July 11, 1995 | | 3. TIME OF DEATH 8:00 P. | |
| 4. SOCIAL SECURITY NUMBER 199-40-8418 | | 5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 84 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) Nov. 24, 1910 | |
| 8. BIRTHPLACE (State or Foreign Country) Maryland | | | | | | | |
| 9a. FACILITY NAME (If not institution, give street and number) Villa Assumpta, 6401 N. Charles St. | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Baltimore | | 9c. COUNTY OF DEATH Baltimore | |
| RESIDENCE OF DECEDENT | | | | | | | |
| 10a. STATE Md. | | 10b. COUNTY Baltimore | | 10c. CITY, TOWN OR LOCATION Baltimore | | 10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| 10e. STREET AND NUMBER 6401 N. Charles St. | | | | 10f. ZIP CODE 21212 | | 10g. CITIZEN OF WHAT COUNTRY? USA | |
| 11. MARITAL STATUS 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 | | 15b. College (13 or +) B.A., MFA 5+ | | 16. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Teacher | | 16b. KIND OF BUSINESS/INDUSTRY Education | |
| 17. FATHER'S NAME (First, Middle, Last) Leon Hoover | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Violet Johnson | | | |
| 19a. INFORMANT'S NAME (Type/Print) S. Bernice Feilinger, SSND | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6401 N. Charles St., Baltimore, Md. 21212 | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Villa Maria Cemetery 7-14 | | DATE 7-14 | | 20c. LOCATION — City or Town, State Glen Arm, Md. | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE  | | | | 22. NAME AND ADDRESS OF FACILITY Mitchell-Wiedefeld Home 6500 York Rd. Baltimore, Maryland 21212 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Aortic Stenosis | | | | | | | Approximate Interval Between Onset and Death |
| a. DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| b. DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| c. DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. CORONARY Artery disease CHRONIC obstructive PULMONARY disease CONGESTIVE HEART FAILURE | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> OOA | | 28. PLACE OF DEATH (Check only one) OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER  | | | | 29c. LICENSE NUMBER D15871 | | 29d. DATE SIGNED (Month, Day, Year) July 12, 1995 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Dr. Lawrence Boas, M.D., 54 Scott Adam Road, Cockeysville, Md. 21030 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JUL 17 1995 | | | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

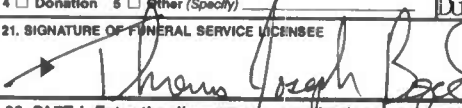
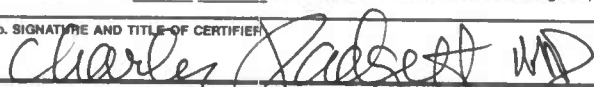
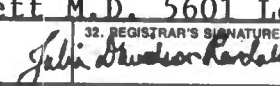
DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 21505

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|---|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) Selma Regina Johnson | | | | 2. DATE OF DEATH MONTH DAY YEAR July 15, 1995 | | 3. TIME OF DEATH 6:06 a^m | |
| 4. SOCIAL SECURITY NUMBER 217-01-3546 | | 5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 79 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) Feb. 11, 1916 | |
| 8. FACILITY NAME (If not institution, give street and number) Union Memorial Hospital | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Baltimore | | 9c. COUNTY OF DEATH N/A | |
| 10a. STATE Maryland | | | | 10b. COUNTY N/A | | 10c. CITY, TOWN OR LOCATION Baltimore | |
| 10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | | | | | | |
| 10e. STREET AND NUMBER 3202 Avon Avenue | | | | 10f. ZIP CODE 21218 | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: white | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 years College (1-4 or 5+) Clerk/Typist | | | | 16. KIND OF BUSINESS/INDUSTRY MD St. Dept. of Health | | | |
| 17. FATHER'S NAME (First, Middle, Last) Oscar Thomas Cecil | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Selma Gibson | | | |
| 19a. INFORMANT'S NAME (Type/Print) Edward H. Johnson | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3202 Avon Avenue, Baltimore, MD 21218 | | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Dulaney Valley Memorial Gardens July 18 Timonium, Maryland | | 20c. LOCATION — City or Town, State | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE  | | | | 22. NAME AND ADDRESS OF FACILITY Mitchell-Wiedefeld Home Inc. 6500 York Road, Baltimore, MD 21212 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Carcinomatosis DUE TO (OR AS A CONSEQUENCE OF): b. Breast Carcinoma DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Approximate Interval Between Onset and Death 3 mon. 5 yrs | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| 29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER  Charles Padgett M.D. | | | | 29c. LICENSE NUMBER D15546 | | 29d. DATE SIGNED (Month, Day, Year) July 17, 1995 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Charles Padgett M.D. 5601 Loch Raven Blvd. Suite 107 Balto. MD 21239 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JUL 17 1995 | | | | 32. REGISTRAR'S SIGNATURE  | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL DR. ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR
1 - STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|---|--|--|--|--|---|
| 1. DECEDENT'S NAME (First, Middle, Last) <u>Joseph McKinley Jones</u> | | | | 2. DATE OF DEATH MONTH <u>July</u> DAY <u>76</u> YEAR <u>1995</u> | | 3. TIME OF DEATH <u>4:00 P M</u> | |
| 4. SOCIAL SECURITY NUMBER <u>225-24-5561</u> | | 5. SEX <u>1</u> M <u>2</u> F | | 6. AGE (In yrs. last birthday) <u>73</u> YRS. | | 7. DATE OF BIRTH (Month, Day, Year) <u>May 27 1922</u> | |
| 8. BIRTHPLACE (State or Foreign Country) <u>VA</u> | | | | 9a. FACILITY NAME (If not institution, give street and number) <u>Augsburg Nursing Home</u> | | 9b. CITY, TOWN OR LOCATION OF DEATH <u>Balto.</u> | |
| 10a. STATE <u>MD</u> | | | | 10b. COUNTY <u>Balto</u> | | 10c. CITY, TOWN OR LOCATION <u>Balto</u> | |
| 10d. INSIDE CITY LIMITS? <u>1</u> YES <u>2</u> NO | | | | 10e. STREET AND NUMBER <u>6811 Campfield Road</u> | | 10f. ZIP CODE <u>21207</u> | |
| 10g. CITIZEN OF WHAT COUNTRY? <u>USA</u> | | | | 11. MARITAL STATUS <u>3</u> Never Married <u>2</u> Married <u>3</u> Widowed <u>4</u> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <u>1</u> YES <u>2</u> NO IF YES, GIVE WAR OR DATES <u>Army WWII</u> | |
| 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <u>1</u> YES <u>2</u> NO Specify: | | | | 14. RACE — American Indian, Black, White, etc. Specify: <u>Black</u> | | 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <u>12th</u> College (13-16) <u>NA</u> | |
| 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <u>unknown</u> | | | | 16b. KIND OF BUSINESS/INDUSTRY <u>unknown</u> | | | |
| 17. FATHER'S NAME (First, Middle, Last) <u>James Jones</u> | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) <u>Ann Tucker</u> | | | |
| 19. INFORMANT'S NAME (Type/Print) <u>Patricia Jones</u> | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>2626 Marbourne Ave. Balto. Md 21230</u> | | | |
| 20a. METHOD OF DISPOSITION <u>1</u> Burial <u>2</u> Cremation <u>3</u> Removal from State <u>4</u> Donation <u>5</u> Other (Specify) | | | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <u>Garrison Forest Vet. Cem. 7-10-95 Owings Mills, Md</u> | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <u>Thymis B. Scott</u> | | | | 22. NAME AND ADDRESS OF FACILITY <u>March Funeral Home-West 4300 Wabash Ave. Balto. 21215</u> | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <u>TERMINAL LUNG CANCER - METASTATIC SMALL CELL CARCINOMA</u> DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | | Approximate interval Between Onset and Death <u>6 months</u> |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/></u> | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? <u>1</u> YES <u>2</u> NO |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <u>1</u> YES <u>2</u> NO | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <u>1</u> YES <u>2</u> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <u>1</u> Inpatient <u>2</u> ER/Outpatient <u>3</u> DOA OTHER: <u>4</u> Nursing Home <u>5</u> Residence <u>6</u> Other (Specify) | | | | | |
| 27. MANNER OF DEATH <u>1</u> Natural <u>5</u> Pending Investigation <u>2</u> Accident <u>3</u> Suicide <u>4</u> Homicide <u>6</u> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY <u>M</u> | | 28c. INJURY AT WORK? <u>1</u> YES <u>2</u> NO | |
| 28d. DESCRIBE NOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one) <u>1</u> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <u>2</u> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER <u>Deborah T. Pierce DO</u> | | | | 29c. LICENSE NUMBER <u>D45931</u> | | 29d. DATE SIGNED (Month, Day, Year) <u>JULY SEVENTH</u> | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <u>Deborah T. Pierce 7220 Park Heights Balto Md 21208</u> | | | | | | | |
| 31. DATE FILED (Month, Day, Year) <u>JUL 17 1995</u> | | | | 32. REGISTRAR'S SIGNATURE <u>John Andrew Rickett</u> | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 21507

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) CAROLYN JONES | | | | 2. DATE OF DEATH MONTH DAY YEAR JULY 13, 1995 | | 3. TIME OF DEATH 02:13A M | |
| 4. SOCIAL SECURITY NUMBER 213-46-2731 | | 5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 48 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) NOV. 16, 1946 | |
| 8. BIRTHPLACE (State or Foreign Country) MARYLAND | | | | 9a. FACILITY NAME (If not institution, give street and number) THE JOHNS HOPKINS HOSPITAL | | 9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE CITY | |
| 9c. COUNTY OF DEATH n/a | | | | 10a. STATE MARYLAND | | | |
| 10b. COUNTY n/a | | | | 10c. CITY, TOWN OR LOCATION BALTIMORE | | | |
| 10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | 10e. STREET AND NUMBER 2212 WALSHIRE AVENUE | | | |
| 10f. ZIP CODE 21214 | | | | 10g. CITIZEN OF WHAT COUNTRY? UNITED STATES | | | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: BLACK | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (9-12) College (1-4 or 5+) 12 TH - | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) HOMEMAKER | | 16b. KIND OF BUSINESS/INDUSTRY in own home | |
| 17. FATHER'S NAME (First, Middle, Last) SAMUEL S. CONWAY | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) DORIS BROWN | | | |
| 19a. INFORMANT'S NAME (Type/Print) PHYLLIS T. JONES | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2212 WALSHIRE AVENUE, BALTIMORE, MD 21214 | | | |
| 20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) GREENMOUNT CEMETERY 7-14 | | 20c. LOCATION — City or Town, State BALTIMORE, MD | | 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | |
| 22. NAME AND ADDRESS OF FACILITY WMC. MARCH FH.-1101 E. NORTH AVE. | | 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Cardiac Arrest DUE TO (OR AS A CONSEQUENCE OF): b. Myocardial Infarction DUE TO (OR AS A CONSEQUENCE OF): c. intra-Abdominal bleeding DUE TO (OR AS A CONSEQUENCE OF): d. Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Systemic Lupus Erythematosus | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Homicide 8 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER | | | | 29c. LICENSE NUMBER MD054013 | | 29d. DATE SIGNED (Month/Day/Year) 07/13/95 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Francisco J. Torre Johns Hopkins University Hosp. | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JUL 17 1995 | | 32. REGISTRAR'S SIGNATURE | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

513-46-5731

xx 48

NOV. 16, 1946 MARYLAND

n/a

MARYLAND

n/a

BALTIMORE

XX

5215 WALSHIRE AVENUE

5214

UNITED STATES

XX

XX

BLACK

IS TH

HOMEMAKER

in own home

SAMUEL S. CONWAY

DORIS BROWN

PHYLLIS T. JONES

5215 WALSHIRE AVENUE, BALTIMORE, MD 5214

GREENMOUNT CEMETERY 7-14 BALTIMORE, MD

WMC. MARCH FH.-1101 E. NORTH AVE.

95 21508

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|---|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) HENRY WALLIS KETTELL | | | | 2. DATE OF DEATH MONTH JULY DAY 15 YEAR 1995 | | 3. TIME OF DEATH 7:15 P.M. | |
| 4. SOCIAL SECURITY NUMBER 212-05-9594 | | 5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (in yrs. last birthday) 82 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) OCT. 15 1912 | |
| 8. BIRTHPLACE (State or Foreign Country) MD. | | | | 9. FACILITY NAME (If not institution, give street and number) 7014 HOLABIRD AVENUE | | 10. CITY, TOWN OR LOCATION OF DEATH DUNDALK | |
| 11. RESIDENCE OF DECEDENT MD. | | | | 12. COUNTY BALTIMORE | | 13. COUNTY OF DEATH BALTIMORE | |
| 14. STREET AND NUMBER 7014 HOLABIRD AVENUE | | | | 15. ZIP CODE 21222 | | 16. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 17. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 18. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 19. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 20. RACE — American Indian, Black, White, etc. Specify: WHITE | |
| 21. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <input type="checkbox"/> College (14 or 5+) <input checked="" type="checkbox"/> 3 YRS. | | 22. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) ELECTRICAL ENGINEER | | 23. KIND OF BUSINESS/INDUSTRY STEEL. | | | |
| 24. FATHER'S NAME (First, Middle, Last) HARRY DOWNES KETTELL | | | | 25. MOTHER'S NAME (First, Middle, Maiden Surname) LOUISE WALLIS | | | |
| 26. INFORMANT'S NAME (Type/Print) MILDRED KETTELL | | | | 27. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7014 HOLABIRD AVENUE BALTO. MD 21222 | | | |
| 28. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 29. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) PARKWOOD CEMETERY 7/18 | | 30. LOCATION — City or Town, State BALTO. MD. | | 31. SIGNATURE OF FUNERAL SERVICE LICENSEE Anthony Cdt Connolly | |
| 32. NAME AND ADDRESS OF FACILITY Connolly Funeral Home of Dundalk 710 Solfers PT. RD. BALTO. MD 21222 | | 33. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. UNDIFFERENTIATED CARCINOMA - LUNG CANCER VS MESOTHELIOMA DUE TO (OR AS A CONSEQUENCE OF): 9 months | | | | Approximate Interval Between Onset and Death | |
| 34. Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): | | 35. PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. PARKINSON'S DEMENTIA | | | | 36. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 37. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | 38. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | | |
| 39. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 40. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 41. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide | | 42. DATE OF INJURY (Month, Day, Year) | | 43. TIME OF INJURY M | | 44. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 45. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 46. DESCRIBE HOW INJURY OCCURRED | | | | | |
| 47. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | 48. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | |
| 49. SIGNATURE AND TITLE OF CERTIFIER [Signature] MD | | 50. LICENSE NUMBER 138409 | | 51. DATE SIGNED (Month, Day, Year) 7/17/95 | | | |
| 52. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 4440 EUSTAN AVS BALTIMORE, MD, 21224 | | | | | | | |
| 53. DATE FILED (Month, Day, Year) JUL 17 1995 | | | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

218468415

95 21509

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|---|--|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last) Karen A. Knapp | | | | 2. DATE OF DEATH MONTH 07 DAY 14 YEAR 95 | | 3. TIME OF DEATH 12:20 PM | |
| 4. SOCIAL SECURITY NUMBER 218 468 415 | | 5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 47 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 12/15/47 | |
| 9a. FACILITY NAME (If not institution, give street and number) Good Samaritan Hospital | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Baltimore | | 9c. COUNTY OF DEATH | |
| RESIDENCE OF DECEDENT | | | | 10c. CITY, TOWN OR LOCATION Baltimore | | 10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input type="checkbox"/> NO | |
| 10a. STATE MD | | 10b. COUNTY B | | 10e. STREET AND NUMBER 6429 Hartwood St | | 10f. ZIP CODE 21224 | |
| 11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: Caucasian | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 11th College (1-4 or 5+) NO | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) COMMUNITY SERVANT | | 16b. KIND OF BUSINESS/INDUSTRY CITY COUNCIL | | | |
| 17. FATHER'S NAME (First, Middle, Last) UNKNOWN | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) UNKNOWN | | | |
| 19a. INFORMANT'S NAME (Type/Print) DANIEL W. KNAPP | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6429 HARTWAIT ST. BALTO. MD 21224 | | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) ST. STANISLAUS | | DATE 7/18 | | 20c. LOCATION — City or Town, State BALTO. MD. | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Anthony Colt Connelly | | | | 22. NAME AND ADDRESS OF FACILITY CONNELLY FUNERAL HOME OF Dundalk 7110 Solters PT. RD. BALTO MD 21222 | | | |
| 23. PART I. Enter the disease(s) or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Multi-system organ failure DUE TO (OR AS A CONSEQUENCE OF): Septic DUE TO (OR AS A CONSEQUENCE OF): Systemic lupus erythematosus DUE TO (OR AS A CONSEQUENCE OF): 10 yrs | | | | | | | Approximate Interval Between Onset and Death 1 week 2 weeks 10 yrs |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO | | | | | | | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, term, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER Stuart Q. Wiles MD | | | | 29c. LICENSE NUMBER D36663 | | 29d. DATE SIGNED (Month, Day, Year) 07/14/95 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Good Samaritan Hospital, Baltimore, MD | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JUL 17 1995 | | | | 32. REGISTRAR'S SIGNATURE John Anderson Parkell | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

68760

3

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filed in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.


IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1952-1953 (1954-1955)

95 21510

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|--|--|--|--|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last) Joseph Kauffman | | | | 2. DATE OF DEATH MONTH DAY YEAR JULY 11 1995 | | 3. TIME OF DEATH 11:39 P M | |
| 4. SOCIAL SECURITY NUMBER 218-18-7335 | | 5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 72 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 11-29-22 | |
| 9a. FACILITY NAME (If not institution, give street and number) Sinai Hospital | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Baltimore | | 9c. COUNTY OF DEATH n/a | |
| 10a. STATE Maryland | | 10b. COUNTY Baltimore | | 10c. CITY, TOWN OR LOCATION Towson | | 10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| 10e. STREET AND NUMBER 608 E. Seminary Ave. | | | | 10f. ZIP CODE 21286 | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES WW II | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 4 yrs | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) President-CEO | | 16b. KIND OF BUSINESS/INDUSTRY Kauffman Electric Co. | | | |
| 17. FATHER'S NAME (First, Middle, Last) Joseph Ulrich Kauffman | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Fannia Umberger | | | |
| 19a. INFORMANT'S NAME (Type/Print) Karl B. Kauffman | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 608 E. Seminary Ave. Towson, Md. 21286 | | | |
| 20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Hilltop Service Corp. 7-13 Towson, Md. | | 20c. LOCATION — City or Town, State | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE  | | | | 22. NAME AND ADDRESS OF FACILITY Ruck Towson Funeral Home, Inc. 1050 York Rd. Towson, Md. 21204 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Myocardia Infarction DUE TO (OR AS A CONSEQUENCE OF): b. Pneumonia DUE TO (OR AS A CONSEQUENCE OF): c. Sepsis DUE TO (OR AS A CONSEQUENCE OF): d. Coronary Artery Disease Sequently ill conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | | Approximate Interval Between Onset and Death ~ 7 hours |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | | | 28e. PLACE OF INJURY — All home, farm, street, factory, office building, etc. (Specify) | | | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER E.V. Loeb, M.D. | | | | 29c. LICENSE NUMBER AS2402321EL9837 | | 29d. DATE SIGNED (Month, Day, Year) July 11, 1995 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Elizabeth Loeb - Sinai Hospital Baltimore, Maryland | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JUL 17 1995 | | | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 21511

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | |
|--|--|--|--|---|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) LILLIAN MARY KIRBY | | | | 2. DATE OF DEATH MONTH JULY DAY 09 YEAR 1995 | | | | 3. TIME OF DEATH 3:15 PM | |
| 4. SOCIAL SECURITY NUMBER 212-36-4442 | | 5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 86 YRS. | | IF UNDER 1 YEAR MONTHS 0 DAYS 0 | | IF UNDER 24 HRS. HOURS 0 MIN. 0 | |
| 9a. FACILITY NAME (If not institution, give street and number) GREATER BALTIMORE MEDICAL CENTER | | | | 9b. CITY, TOWN OR LOCATION OF DEATH TOWSON | | | | 9c. COUNTY OF DEATH BALTIMORE | |
| RESIDENCE OF DECEDENT | | | | | | | | | |
| 10a. STATE Maryland | | 10b. COUNTY Baltimore | | 10c. CITY, TOWN OR LOCATION Baltimore | | | | 10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 10e. STREET AND NUMBER 117 A. Dumbarton Road | | | | 10f. ZIP CODE 21212 | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | | | |
| 11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White | | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) College | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Book Store Keeper | | 16b. KIND OF BUSINESS/INDUSTRY University of Maryland | | | |
| 17. FATHER'S NAME (First, Middle, Last) Charles Carson | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Mary Gibson | | | | | |
| 19a. INFORMANT'S NAME (Type/Print) Edwin J. Kirby, Jr. | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 800 Greenspring Valley Road, Lutherville, Md. 21093 | | | | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Moreland Memorial Cemetery | | DATE 7-13-95 | | 20c. LOCATION — City or Town, State Parkville, Maryland | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | | | | 22. NAME AND ADDRESS OF FACILITY Ruck Towson Funeral Home, Inc. 1050 York Road, Towson, Md. 21204 | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Lymphopitelia of Left breast Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Approximate Interval Between Onset and Death 1 year | | | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Aspiration Pneumonia | | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | |
| 27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED | |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | |
| 29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Paul Cerano MD 7/11/95 | | 29b. SIGNATURE AND TITLE OF CERTIFIER | | 29c. LICENSE NUMBER D30929 | | 29d. DATE SIGNED (Month, Day, Year) | | | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Paul Cerano, MD 6569 N Charles St, Baltimore MD 21204 | | | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JUL 17 1995 | | | | | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 21512

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|---|--|--|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) WILLIAM J. LUTHER | | | | 2. DATE OF DEATH MONTH JULY DAY 14 YEAR 1995 | | 3. TIME OF DEATH 4:30 a m | |
| 4. SOCIAL SECURITY NUMBER 275-12-3102 | | 5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 78 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 01 25 17 | |
| 9a. FACILITY NAME (If not institution, give street and number) 5601 LIBERTY TERRACE | | | | 9b. CITY, TOWN OR LOCATION OF DEATH BROOKLYN PARK | | 9c. COUNTY OF DEATH ANNE ARUNDEL | |
| RESIDENCE OF DECEDENT | | | | | | | |
| 10a. STATE MARYLAND | | 10b. COUNTY ANNE ARUNDEL | | 10c. CITY, TOWN OR LOCATION BROOKLYN PARK | | 10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| 10e. STREET AND NUMBER 5601 LIBERTY TERRACE | | | | 10f. ZIP CODE 21225 | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES WW 11 | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: WHITE | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 0 | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) DIESEL MECHANIC | | 16b. KIND OF BUSINESS/INDUSTRY TRUCK REPAIR | | | |
| 17. FATHER'S NAME (First, Middle, Last) LEWIS T. LUTHER | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) CLAUDIA B. SMITH | | | |
| 19a. INFORMANT'S NAME (Type/Print) MARY E. LUTHER | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5601 LIBERTY TERRACE-BROOKLYN PARK, MD 21225 | | | |
| 20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 6 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of crematory, cemetery or other place) METRO CREMATORY, INC. 7/17 | | DATE 7/17 | | 20c. LOCATION — City or Town, State CATONSVILLE, MD. | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Darryl L. Kaufman</i> | | | | 22. NAME AND ADDRESS OF FACILITY RAYMOND C. FINK FUNERAL HOME 21061 426 CRAIN HWY. S.W. GLEN BURNIE, MD. | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | | a. <i>Possible Aspiration (Patient was found dead during sleep)</i> DUE TO (OR AS A CONSEQUENCE OF): b. <i>Chronic affective disorder</i> DUE TO (OR AS A CONSEQUENCE OF): c. <i>Hypothyroidism</i> DUE TO (OR AS A CONSEQUENCE OF): | | | | | |
| Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | |
| | | | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURED | |
| | | | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i> | | | | 29c. LICENSE NUMBER D31927 | | 29d. DATE SIGNED (Month, Day, Year) 7-15-95 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) HO-LAI FENG M.D. 606 HAMMONDA LANE-BALTIMORE, MD. 21225 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JUL 17 1995 | | | | 32. REGISTRAR'S SIGNATURE <i>[Signature]</i> | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

P.O. BOX 68760

6

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 21513

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|---|---|--------------------------------|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) JOSEPH G. MC PHERSON SR. | | | | 2. DATE OF DEATH MONTH JULY 10, DAY 1995 YEAR | | 3. TIME OF DEATH 4:40 a.m. | |
| 4. SOCIAL SECURITY NUMBER 217-16-8113 | | 5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F | 6. AGE (In yrs. last birthday) 71 YRS. | IF UNDER 1 YEAR MONTHS DAYS | IF UNDER 24 HRS. HOURS MIN. | 7. DATE OF BIRTH (Month, Day, Year) SEPT. 19, 1923 | |
| 8. BIRTHPLACE (State or Foreign Country) N. CAROLINA | | | | 9a. FACILITY NAME (If not institution, give street and number) 150 CARVER ROAD | | 9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE CITY | |
| 9c. COUNTY OF DEATH n/a | | | | 10a. STATE MARYLAND | | 10b. COUNTY n/a | |
| 10c. CITY, TOWN OR LOCATION BALTIMORE | | | | 10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | 10e. STREET AND NUMBER 150 CARVER ROAD | |
| 10f. ZIP CODE 21222 | | | | 10g. CITIZEN OF WHAT COUNTRY? UNITED STATES | | 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES NAVY 8-5-43/1-4-46 | | | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: BLACK | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 th College (1-4 or 5+) — | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) MECHANIC | | 16b. KIND OF BUSINESS/INDUSTRY GENERAL MOTORS | |
| 17. FATHER'S NAME (First, Middle, Last) ANGISH MC PHERSON | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) DOROTHY SHAW | | | |
| 19a. INFORMANT'S NAME (Type/Print) JOSEPH H. MC PHERSON JR. | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 150 CARVER ROAD, BALTIMORE, MD 21222 | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 6 <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) GARRISON FOREST VA CEM. 7-14 | | 20c. LOCATION — City or Town, State OWINGS MILLS, MD | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>A. Valencia Holland</i> | | | | 22. NAME AND ADDRESS OF FACILITY WM.C. MARCH FH.-1101 E. NORTH AVE. | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <i>Chronic Renal Failure</i> DUE TO (OR AS A CONSEQUENCE OF): b. <i>Peripheral Vascular Disease</i> DUE TO (OR AS A CONSEQUENCE OF): c. <i>CAD SIP MI</i> DUE TO (OR AS A CONSEQUENCE OF): d. <i>Hypertension</i> Approximate Interval Between Onset and Death | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER <i>Minnaus</i> | | | | 29c. LICENSE NUMBER D08093 | | 29d. DATE SIGNED (Month, Day, Year) 7/17/95 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 3500 Breckins Lane Balto 21213 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JUL 17 1995 | | | | 32. REGISTRAR'S SIGNATURE <i>John D. ...</i> | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 21514

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) <i>Daniel P. Murphy, Jr.</i> | | | | 2. DATE OF DEATH MONTH <i>07</i> DAY <i>15</i> YEAR <i>95</i> | | 3. TIME OF DEATH <i>1802</i> M | |
| 4. SOCIAL SECURITY NUMBER <i>092-22-2800</i> | | 5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) <i>65</i> YRS. | | 7. DATE OF BIRTH (Month, Day, Year) <i>1-27-1930</i> | |
| 8. BIRTHPLACE (State or Foreign Country) <i>New York</i> | | | | 9a. FACILITY NAME (If not institution, give street and number) <i>Sinai Hospital</i> | | 9b. CITY, TOWN OR LOCATION OF DEATH <i>Baltimore</i> | |
| 9c. COUNTY OF DEATH <i>City</i> | | | | 10a. STATE <i>Maryland</i> | | 10b. COUNTY <i>Baltimore</i> | |
| 10c. CITY, TOWN OR LOCATION <i>Reisterstown</i> | | | | 10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 10e. STREET AND NUMBER <i>414 Gwynnwest Rd.</i> | |
| 10f. ZIP CODE <i>21136</i> | | | | 10g. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i> | | 11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES <i>1948-1958</i> | | | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: <i>White</i> | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <i>12</i> College (1-4 or 5+) <i>8</i> | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <i>Systems Analyst</i> | | 16b. KIND OF BUSINESS/INDUSTRY <i>Social Security</i> | |
| 17. FATHER'S NAME (First, Middle, Last) <i>Daniel Paul Murphy, Sr.</i> | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) <i>Mary Frances Hayes</i> | | | |
| 19a. INFORMANT'S NAME (Type/Print) <i>Barbara A. Murphy</i> | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>414 Gwynnwest Rd. Reisterstown, MD. 21136</i> | | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <i>Maryland Veterans Cem. 7-18-1995</i> | | 20c. LOCATION — City or Town, State <i>Owings Mills, MD.</i> | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>J. Heath Eckhardt</i> | | | | 22. NAME AND ADDRESS OF FACILITY <i>Eckhardt Funeral Chapel 11605 Reisterstown Rd. Owings Mills, MD. 21117</i> | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Multiple organ system failure</i> | | | | | | | |
| DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | | |
| DUE TO (OR AS A CONSEQUENCE OF): <i>acute renal insufficiency</i> | | | | | | | |
| DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Metastatic rectal adenocarcinoma</i> | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | |
| 27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | |
| 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | 28d. DESCRIBE HOW INJURY OCCURRED | | | |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER <i>Joel A. Pearlman M.D. PhD</i> | | | | 29c. LICENSE NUMBER <i>9952</i> | | 29d. DATE SIGNED (Month, Day, Year) <i>07-15-95</i> | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>Joel A. Pearlman Sinai Hospital Baltimore, MD</i> | | | | | | | |
| 31. DATE FILED (Month, Day, Year) <i>JUL 17 1995</i> | | | | 32. REGISTRAR'S SIGNATURE <i>John J. Eckhardt</i> | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

6

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.




TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 21515

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|---|--|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last) ALBERT Peter PRANINSKAS | | | | 2. DATE OF DEATH MONTH DAY YEAR Jul 14 1995 | | 3. TIME OF DEATH 7:34 pm | |
| 4. SOCIAL SECURITY NUMBER 215-09-7612 | | 5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 87 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) May 1, 1908 | |
| 8. BIRTHPLACE (State or Foreign Country) Maryland | | | | 9a. FACILITY NAME (If not institution, give street and number) Saint Joseph Medical Center | | 9b. CITY, TOWN OR LOCATION OF DEATH Towson, Maryland | |
| 9c. COUNTY OF DEATH Baltimore | | | | 10a. STATE Maryland | | 10b. COUNTY N/A | |
| 10c. CITY, TOWN OR LOCATION Baltimore | | | | 10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | | |
| 10e. STREET AND NUMBER 4223 Bayonne Avenue | | | | 10f. ZIP CODE 21206 | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 6 College (1-4 or 5+) | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Tailor | | 16b. KIND OF BUSINESS/INDUSTRY Clothing | | | |
| 17. FATHER'S NAME (First, Middle, Last) Alphonsus Praninskas | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Anna Unknown | | | |
| 19a. INFORMANT'S NAME (Type/Print) Viola A. Praninskas | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4223 Bayonne Avenue Baltimore, Md 21206 | | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Most Holy Redeemer July 17, 1995 | | 20c. LOCATION — City or Town, State Balto. Maryland | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE  | | | | 22. NAME AND ADDRESS OF FACILITY Leonard J. Ruck, Inc. 5305 Harford Road Balto. Md. 21214 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. METASTATIC MELANOMA DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. | | | | | | | Approximate Interval Between Onset and Death 1 YEAR |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | | | | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/> | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| | | 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER  M.D. | | | | 29c. LICENSE NUMBER D16492 | | 29d. DATE SIGNED (Month, Day, Year) July 14, 1995 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) BEATRIZ P. DIZON, M.D. | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JUL 17 1995 | | | | 32. REGISTRAR'S SIGNATURE  | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 21516

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|--|--|---|--|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last) Josephine Theresa Price | | | | 2. DATE OF DEATH MONTH July DAY 17 YEAR 1995 | | 3. TIME OF DEATH 3:00 a.m. | |
| 4. SOCIAL SECURITY NUMBER 216-18-9333 | | 5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 8. AGE (In yrs. last birthday) 69 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) August 16, 1925 | |
| 6. FACILITY NAME (If not institution, give street and number) 5622 Midwood Avenue | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Baltimore | | 9c. COUNTY OF DEATH N/A | |
| 10a. STATE Maryland | | | | 10b. COUNTY N/A | | 10c. CITY, TOWN OR LOCATION Baltimore | |
| 10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | | | 10e. STREET AND NUMBER 5622 Midwood Avenue | | | |
| 10f. ZIP CODE 21212 | | | | 10g. CITIZEN OF WHAT COUNTRY? USA | | | |
| 11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 12 | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Claims Adjustor | | 16b. KIND OF BUSINESS/INDUSTRY Insurance | | | |
| 17. FATHER'S NAME (First, Middle, Last) Catino DiMario | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Mary Marciano | | | |
| 19a. INFORMANT'S NAME (Type/Print) Carson E. Price | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5622 Midwood Avenue Baltimore, Maryland 21212 | | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Sacred Heart of Jesus | | DATE 7/19 | | 20c. LOCATION — City or Town, State Baltimore, Maryland | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSER <i>Denise Hepler Konakis</i> | | | | 22. NAME AND ADDRESS OF FACILITY Mitchell-Wiedefeld Home Inc. 6500 York Rd. Baltimore, MD 21212 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Pneumonia Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. Due to (or as a consequence of): Amiotrophic Lateral sclerosis b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. | | | | | | | Approximate interval Between Onset and Death one day 5 yrs |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO | | | | | | | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER <i>Denis MacDonald M.D.</i> | | | | 29c. LICENSE NUMBER D1540 8 | | 29d. DATE SIGNED (Month, Day, Year) 5/17/95 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Denis MacDonald M.D. 9 South Highland Ave. Baltimore, MD 21224 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JUL 17 1995 | | 32. REGISTRAR'S SIGNATURE <i>John Brundage</i> | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95-3888-510

JHM

UNKNOWN 95-161

95 21517

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) KEVIN CORNELL ROSS | | | | 2. DATE OF DEATH JULY 5 1995 11:16 A | | 3. TIME OF DEATH 11:16 A | |
| 4. SOCIAL SECURITY NUMBER 213-64-5119 | | 5. SEX 1 M 2 F | | 6. AGE (In yrs. last birthday) 39 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 3/25/1956 | |
| 8. BIRTHPLACE (State or Foreign Country) Balto., MD | | 9a. FACILITY NAME (If not institution, give street and number) 4701 GREENSPRING AVE | | 9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE | | 9c. COUNTY OF DEATH n/a | |
| RESIDENCE OF DECEDENT | | | | | | | |
| 10a. STATE Maryland | | 10b. COUNTY n/a | | 10c. CITY, TOWN OR LOCATION Baltimore | | 10d. INSIDE CITY LIMITS? 1 X YES 2 NO | |
| 10e. STREET AND NUMBER 3318 Burleith Avenue | | | | 10f. ZIP CODE 21215 | | 10g. CITIZEN OF WHAT COUNTRY? USA | |
| 11. MARITAL STATUS 1 X Never Married 2 Married 3 Widowed 4 Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 X NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 YES 2 X NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: Black | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12th College (1-4 or 5+) 2 | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Salesperson | | 16b. KIND OF BUSINESS/INDUSTRY Car Dealership | | | |
| 17. FATHER'S NAME (First, Middle, Last) David A. Ross | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Ann Louise Gunter | | | |
| 19a. INFORMANT'S NAME (Type/Print) Credella Joynes | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3318 Burleith Avenue Balto., MD. 21215 | | | |
| 20a. METHOD OF DISPOSITION 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Meadowridge Cemetery 7/13 | | 20c. LOCATION — City or Town, State Baltimore, Maryland | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Leroy O. Dyett</i> | | | | 22. NAME AND ADDRESS OF FACILITY LEROY O. DYETT & SON FUNERAL HOME 4600 Liberty Heights Avenue 21207 | | | |
| 23. PART I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Multiple Myeloma DUE TO (OR AS A CONSEQUENCE OF): Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. | | | | | | | Approximate interval Between Onset and Death |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 X YES 2 NO |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 X YES 2 NO | | | | | | | DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/> |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 Inpatient 2 ER/Outpatient 3 DOA OTHER: 4 Nursing Home 5 Residence 6 X Other (Specify) IN FIELD | | | | | |
| 27. MANNER OF DEATH 1 Natural 2 Accident 3 Suicide 4 Homicide 5 Pending investigation 6 Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) Found 7/5/95 | | 28b. TIME OF INJURY 11:15 PM | | 28c. INJURY AT WORK? 1 YES 2 NO | |
| 28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) Field | | 28e. DESCRIBE HOW INJURY OCCURRED subject struck by vehicle | | | | | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) 4701 Greenspring Avenue | | | | | | | |
| 29a. CERTIFIER (Check only one) 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 X MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER <i>Theodore M. King MD</i> | | | | 29c. LICENSE NUMBER O.C.M.E. | | 29d. DATE SIGNED (Month, Day, Year) JULY 5, 1995 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) THEODORE M. KING 111 Penn Street, Baltimore, Maryland 21201 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JUL 12 1995 | | | | 32. REGISTRAR'S SIGNATURE <i>John A. ...</i> | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 21518

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|--|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) <i>Mattie Roosevelt</i> | | | | 2. DATE OF DEATH MONTH <i>July</i> DAY <i>13</i> YEAR <i>1995</i> | | 3. TIME OF DEATH <i>1250 A.M.</i> | |
| 4. SOCIAL SECURITY NUMBER <i>214-16-8153</i> | | 5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) <i>79</i> YRS. | | 7. DATE OF BIRTH (Month, Day, Year) <i>Jan 25, 1916</i> | |
| 8a. FACILITY NAME (If not institution, give street and number) <i>Levindale Nursing Home</i> | | | | 8b. CITY, TOWN OR LOCATION OF DEATH <i>Balto</i> | | 8c. COUNTY OF DEATH <i>N/A</i> | |
| 10a. STATE <i>md</i> | | | | 10b. COUNTY <i>N/A</i> | | 10c. CITY, TOWN OR LOCATION <i>Balto</i> | |
| 10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | | | 10e. STREET AND NUMBER <i>2434 E. Biddle St.</i> | | 10f. ZIP CODE <i>21213</i> | |
| 10g. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i> | | | | 11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | |
| 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | | | 14. RACE — American Indian, Black, White, etc. Specify: <i>Black</i> | | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <i>6th</i> College (14 or 5+) <i>N/A</i> | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <i>Domestic</i> | | 16b. KIND OF BUSINESS/INDUSTRY <i>Home</i> | |
| 17. FATHER'S NAME (First, Middle, Last) <i>John Hailey</i> | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) <i>Stanna Quick</i> | | | |
| 19a. INFORMANT'S NAME (Type/Print) <i>Valerie R. Boyd</i> | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>1665 Woodbourne Ave Balto md 21239</i> | | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <i>King Memorial Pk 7/18/95</i> | | 20c. LOCATION — City or Town, State <i>Randallstown, md</i> | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Bladys Wane</i> | | | | 22. NAME AND ADDRESS OF FACILITY <i>Mark F. West 4300 Wabash Ave</i> | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <i>acute - cardio - pulmonary arrest</i> DUE TO (OR AS A CONSEQUENCE OF): b. <i>coronary artery disease</i> DUE TO (OR AS A CONSEQUENCE OF): c. _____ DUE TO (OR AS A CONSEQUENCE OF): d. _____ Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>anemia hypertension osteomyelitis Alzheimer's disease multiple deubiti/urinary tract infections</i> | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | |
| 27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY <i>M</i> | |
| 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | 28d. DESCRIBE HOW INJURY OCCURRED | | | |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER <i>Consuelo Alvarez MD</i> | | | | 29c. LICENSE NUMBER <i>D: 44907</i> | | 29d. DATE SIGNED (Month, Day, Year) <i>July 13th 1995</i> | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>Levindale Geriatric Center / Hospital Baltimore, MD 21217</i> | | | | | | | |
| 31. DATE FILED (Month, Day, Year) <i>JUL 17 1995</i> | | | | 32. REGISTRAR SIGNATURE <i>John D. ...</i> | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 21519

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|--|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) Charles William Rampulla | | | | 2. DATE OF DEATH MONTH DAY YEAR July 12, 1995 | | 3. TIME OF DEATH 10:10 P. M. | |
| 4. SOCIAL SECURITY NUMBER 210-24-1852 | | 5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 62 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) June 17, 1933 | |
| 8. BIRTHPLACE (State or Foreign Country) Pennsylvania | | | | 9a. FACILITY NAME (If not institution, give street and number) 905 Carroll Avenue | | 9b. CITY, TOWN OR LOCATION OF DEATH Laurel | |
| 9c. COUNTY OF DEATH Prince George | | | | 10a. STATE Maryland | | 10b. COUNTY Prince George | |
| 10c. CITY, TOWN OR LOCATION Laurel | | | | 10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 10e. STREET AND NUMBER 905 Carroll Avenue | |
| 10f. ZIP CODE 20707 | | | | 10g. CITIZEN OF WHAT COUNTRY? USA | | 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES 6/1953 -- 5/1955 | | | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 0 | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Carpenter | | 16b. KIND OF BUSINESS/INDUSTRY Manor Care | |
| 17. FATHER'S NAME (First, Middle, Last) Joseph Rampulla | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Felicia Glorioso | | | |
| 19a. INFORMANT'S NAME (Type/Print) Margaret Rampulla | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 905 Carroll Avenue, Laurel, Maryland 20707 | | | |
| 20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Baltimore Washington Crematory 7/13 | | 20c. LOCATION — City or Town, State Laurel, Maryland | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i> | | | | 22. NAME AND ADDRESS OF FACILITY Fleck Funeral Home, Inc. 7601 Sandy Spring Road, Laurel, MD 20707 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <i>Metastatic Lung Cancer</i> DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Nomicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i> | | | | 29c. LICENSE NUMBER 038509 | | 29d. DATE SIGNED (Month, Day, Year) July 13 1995 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Michelle Koutrelakos 11065 Little Portersport Pkwy Columbia MD 21046 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JUL 17 1995 | | | | | | | |

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1041

95 21520

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) THEODORE W. RICE | | | | 2. DATE OF DEATH MONTH 7 DAY 8 YEAR 95 | | 3. TIME OF DEATH 2:45 AM | |
| 4. SOCIAL SECURITY NUMBER 219 28 2379 | | 5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 61 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 4/22/34 | |
| 9a. FACILITY NAME (If not institution, give street and number) (HOME) 3615 FOREST HILL RD. | | | | 9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE | | 9c. COUNTY OF DEATH BALTO. | |
| RESIDENCE OF DECEDENT | | | | | | | |
| 10a. STATE MD. | | 10b. COUNTY BALTIMORE | | 10c. CITY, TOWN OR LOCATION BALTIMORE | | 10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 10e. STREET AND NUMBER 3615 FOREST HILL RD, | | | | 10f. ZIP CODE 21207 | | 10g. CITIZEN OF WHAT COUNTRY? USA | |
| 11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: AFR. AMERICAN | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 0 | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) RETIRED (DISABILITY) | | 16b. KIND OF BUSINESS/INDUSTRY ARMON MEAT CO. | | | |
| 17. FATHER'S NAME (First, Middle, Last) E. CLARENCE RICE | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) VIOLET M. RICE | | | |
| 19a. INFORMANT'S NAME (Type/Print) CHERRY B. RICE | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3615 FOREST HILL RD. BALTIMORE, MD. 21207 | | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) KING'S PARK 7/12/95 | | 20c. LOCATION — City or Town, State RANDALLSTOWN, MD. | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Paul A. Deters</i> | | | | 22. NAME AND ADDRESS OF FACILITY ESTEP BROTHERS FUNERAL HOME P.A. 1300 EUTAW PL. BALTO. MD. 21217 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Acute myocardial infarction Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST Severe Hypertensive atherosclerotic cerebral vasculopathy DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Severe COPD, obesity | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO | | | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. SIGNATURE AND TITLE OF CERTIFIER <i>David J. Penn MD</i> | | 29c. LICENSE NUMBER D29928 | | 29d. DATE SIGNED (Month, Day, Year) 7/11/95 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) David J. Penn MD 3635 Old Casert RD. Balt, MD 21208 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JUL 17 1995 | | | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Item 1, 9-725, 7-17-95, perf. h., dk
FOR
STATE
REGISTRAR
STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH
REG. NO.

| | | | | |
|---|--|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last) OLEN HENRY | | 2. DATE OF DEATH MONTH JULY DAY 11 YEAR 1995 | | 3. TIME OF DEATH 1319 P. M. |
| 4. SOCIAL SECURITY NUMBER 411-24-8624 | 5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F | 6. AGE (In yrs. last birthday) 75 YRS. | 7. DATE OF BIRTH (Month, Day, Year) June 23, 1920 | 8. BIRTHPLACE (State or Foreign Country) Tennessee |
| 9a. FACILITY NAME (If not institution, give street and number) NORTHEAST AUCTION GALLERY | | 9b. CITY, TOWN OR LOCATION OF DEATH ELKTON | | 9c. COUNTY OF DEATH CECIL CO. |
| RESIDENCE OF DECEDENT | | | | |
| 10a. STATE Maryland | 10b. COUNTY N/A | 10c. CITY, TOWN OR LOCATION Baltimore City | | 10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO |
| 10e. STREET AND NUMBER 2849 Lake Avenue | | 10f. ZIP CODE 21213 | | 10g. CITIZEN OF WHAT COUNTRY? United States |
| 11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |
| 14. RACE — American Indian, Black, White, etc. Specify: White | | | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 6 Years College (1-4 or 5+) | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Machinist | | 16b. KIND OF BUSINESS/INDUSTRY Box Factory |
| 17. FATHER'S NAME (First, Middle, Last) Mack Roberts | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Cordie Hopkins | | |
| 19a. INFORMANT'S NAME (Type/Print) Mrs. Maudie I. Roberts | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2849 Lake Ave. Baltimore, MD 21213 | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Gans of Faith Cem. 7/15/1995 | | 20c. LOCATION — City or Town, State Baltimore, MD |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Chuck W. Lush</i> | | 22. NAME AND ADDRESS OF FACILITY Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, MD 21222 | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Multiple Injuries and Compression Asphyxia DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. | | | | Approximate Interval Between Onset and Death |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | 24a. WAS AN AUTOPSY PERFORMED? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | | | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) PARKING LOT | | |
| 27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input checked="" type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 6 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) 7-11-95 | 28b. TIME OF INJURY 1100 M | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |
| 28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) parking lot | | 28d. DESCRIBE HOW INJURY OCCURED subject run over by truck | | |
| 29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. SIGNATURE AND TITLE OF CERTIFIER <i>Dennis J. Chute MD</i> | | 29c. LICENSE NUMBER O.C.M.E. |
| 29d. DATE SIGNED (Month, Day, Year) JULY 12, 1995 | | 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 111 Penn Street, Baltimore, Maryland 21201 | | |
| 31. DATE FILED (Month, Day, Year) JUL 17 1995 | | 32. REGISTRAR'S SIGNATURE <i>John A. Woodard-Randall</i> | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 8 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified.

95 21522

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) John Elwood Snead | | | | 2. DATE OF DEATH MONTH DAY YEAR JULY 10 1995 | | 3. TIME OF DEATH 6:15 P M | |
| 4. SOCIAL SECURITY NUMBER 223-07-3123 | | 5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 84 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) November 10, 1910 | |
| 9a. FACILITY NAME (If not institution, give street and number) Union Memorial Hospital | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Baltimore City | | 9c. COUNTY OF DEATH N/A | |
| 10a. STATE Maryland | | | | 10b. COUNTY N/A | | 10c. CITY, TOWN OR LOCATION Baltimore | |
| 10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | 10e. STREET AND NUMBER 103 Enfield Road | | | |
| 10f. ZIP CODE 21212 | | | | 10g. CITIZEN OF WHAT COUNTRY? USA | | | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (14 or 5+) 4 | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Vice President | | 16b. KIND OF BUSINESS/INDUSTRY Insurance | | | |
| 17. FATHER'S NAME (First, Middle, Last) Albert Burton Snead | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Grace Arrington | | | |
| 19a. INFORMANT'S NAME (Type/Print) John E. Snead Jr | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 317 Broadmoor Road Baltimore, Maryland 21212 | | | |
| 20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Greenmount Cemetery 7/12 Baltimore, Maryland | | 20c. LOCATION — City or Town, State | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Thomas Stephen Knakis</i> | | | | 22. NAME AND ADDRESS OF FACILITY Mitchell-Wiedefeld Home 6500 York Road Baltimore, Maryland 21212 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | | a. Aspiration Pneumonia | | | | Approximate Interval Between Onset and Death 5 DAYS | |
| | | b. Chronic Atrial Fibrillation | | | | 5 YEARS | |
| | | c. Embolic Stroke | | | | 6 DAYS | |
| | | d. | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Congestive Heart Failure | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| | | 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i> MD | | | | 29c. LICENSE NUMBER AT2438946 | | 29d. DATE SIGNED (Month, Day, Year) JULY 10, 1995 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Nelly C. Baez Union Memorial Hospital 201 E. University Pkwy 21218 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JUL 17 1995 | | | | 32. REGISTRAR'S SIGNATURE <i>[Signature]</i> | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.




TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Item #6 G-film 725 per F.H. 7/28/95 P.C.

1 - STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) ROBERT I. SINNOTT SR | | | | 2. DATE OF DEATH MONTH JULY DAY 13 YEAR 1995 | | 3. TIME OF DEATH 3:30 a.m. | |
| 4. SOCIAL SECURITY NUMBER 215-09-4236 | | 5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (in yrs. last birthday) 83 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) Sept. 16 1911 | |
| 8. BIRTHPLACE (State or Foreign Country) Maryland | | | | 9a. FACILITY NAME (If not institution, give street and number) SAINT JOSEPH MEDICAL CENTER | | 9b. CITY, TOWN OR LOCATION OF DEATH TOWSON, MARYLAND | |
| 9c. COUNTY OF DEATH BALTIMORE | | | | 10a. STATE Md. | | 10b. COUNTY Baltimore | |
| 10c. CITY, TOWN OR LOCATION Lutherville | | | | 10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 10e. STREET AND NUMBER 30 Thornhill Rd. | |
| 10f. ZIP CODE 21093 | | | | 10g. CITIZEN OF WHAT COUNTRY? USA | | 11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) +8 | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Lawyer | | 16b. KIND OF BUSINESS/INDUSTRY Social Security Adm. | |
| 17. FATHER'S NAME (First, Middle, Last) Charles E. Sinnott | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Mary Toulan | | | |
| 19a. INFORMANT'S NAME (Type/Print) Helen Sinnott | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 30 Thornhill Rd. Lutherville Md. 21093 | | | |
| 20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input checked="" type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input checked="" type="checkbox"/> Other (Specify) | | | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Bulaney Valley Cemetery 7-17-95 | | 20c. LOCATION — City or Town, State Timonium Md. | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE  | | | | 22. NAME AND ADDRESS OF FACILITY Ruck Towson F.H. 1050 York Rd. Towson Md. 21204 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → METASTATIC CARCINOMA OF UNKNOWN PRIMARY a. DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | | Approximate Interval Between Onset and Death 1 YEAR |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ASPIRATION PNEUMONIA | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | | | | DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/> |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | | | 28e. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. SIGNATURE AND TITLE OF CERTIFIER  | | 29c. LICENSE NUMBER D 41410 | | 29d. DATE SIGNED (Month, Day, Year) 07-13-95 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) JOGINDER P. MEHTA, MD 7620 YORK ROAD TOWSON, MARYLAND 21204 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JUL 17 1995 | | | | 32. REGISTRAR'S SIGNATURE  | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 21524

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | | | |
|--|--|--|---|---|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) Joseph J. Strunge | | | | 2. DATE OF DEATH MONTH DAY YEAR July 11, 1995 | | | | 3. TIME OF DEATH 5:00 P. M | | | |
| 4. SOCIAL SECURITY NUMBER 215-10-0132 | | 5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | 6. AGE (In yrs. last birthday) 86 YRS. | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS. HOURS MIN. | | 7. DATE OF BIRTH (Month, Day, Year) 7-2-1909 | | 8. BIRTHPLACE (State or Foreign Country) Maryland | |
| 9a. FACILITY NAME (If not institution, give street and number) 305 E. Joppa Road Apt 1509 | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Towson | | | | 9c. COUNTY OF DEATH Baltimore | | | |
| RESIDENCE OF DECEDENT | | | | | | | | | | | |
| 10a. STATE Maryland | | 10b. COUNTY Baltimore | | 10c. CITY, TOWN OR LOCATION Towson | | | | 10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | |
| 10e. STREET AND NUMBER 305 E. Joppa Road, Apt. 1509 | | | | 10f. ZIP CODE 21286 | | | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | | | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | | | 14. RACE — American Indian, Black, White, etc. Specify: White | | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 12 | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Plant Foreman | | | | 16b. KIND OF BUSINESS/INDUSTRY Revere Copper & Brass Co. | | | |
| 17. FATHER'S NAME (First, Middle, Last) George Strunge | | | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Magdaline UNKNOWN | | | | | |
| 19a. INFORMANT'S NAME (Type/Print) Mary E. Strunge | | | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) Same As #10 | | | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Most Holy Redeemer Cem. 7-14-95 | | | | 20c. LOCATION — City or Town, State Baltimore, Maryland | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE ▶ Wallace S. Brooks, Jr. | | | | | | 22. NAME AND ADDRESS OF FACILITY Ruck Towson Funeral Home, Inc. 1050 York Road, Towson, Md. 21204 | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. ARTERIO SCLEROTIC CARDIOVASCULAR DISEASE DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | | Approximate Interval Between Onset and Death Year | |
| Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST | | | | | | | | | | | |
| b. DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | | | |
| c. DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | | | |
| d. DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | | | | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| | | | | | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED | | | |
| | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER Marc Levey, M.D. | | | | | | 29c. LICENSE NUMBER D.170411 | | 29d. DATE SIGNED (Month, Day, Year) 12 July 95 | | | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Marc Levey, M.D. 7600 Osler Drive, Towson, Maryland 21204 | | | | | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JUL 17 1995 | | | | 32. REGISTRAR'S SIGNATURE John [Signature] | | | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 687600

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|--|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) Claudius C. Tucker | | | | 2. DATE OF DEATH MONTH July DAY 10 YEAR 95 | | 3. TIME OF DEATH 11:00 A.M. | |
| 4. SOCIAL SECURITY NUMBER 250-18-3069 | | 5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 83 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 05/21/31 | |
| 8. BIRTHPLACE (State or Foreign Country) S. Carolina | | | | 9a. FACILITY NAME (If not institution, give street and number) Seton Hill Manor Nursing Home | | 9b. CITY, TOWN OR LOCATION OF DEATH Baltimore | |
| 9c. COUNTY OF DEATH N/A | | | | 10a. STATE MD. | | 10b. COUNTY N/A | |
| 10c. CITY, TOWN OR LOCATION Baltimore | | | | 10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | 10e. STREET AND NUMBER 1123 W. Saratoga Street | |
| 10f. ZIP CODE 21223 | | | | 10g. CITIZEN OF WHAT COUNTRY? U.S. | | 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES 3-44/10-44 Army | | | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | | |
| 14. RACE — American Indian, Black, White, etc. Specify: Black | | | | 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12th College (1-4 or 5+) 0 | | | |
| 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Driver | | | | 16b. KIND OF BUSINESS/INDUSTRY Trucking | | | |
| 17. FATHER'S NAME (First, Middle, Last) Unknown Walter Tucker | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Unknown Ethel Acter | | | |
| 19a. INFORMANT'S NAME (Type/Print) Dorothy Hill | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1123 W. Saratoga Street Balto., MD. 21223 | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Garrison Forest Vet. 7/14 | | | |
| 20c. LOCATION — City or Town, State Owingsmills, MD. | | | | 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Dorothy Hill CFSP #281 | | | |
| 22. NAME AND ADDRESS OF FACILITY 1721-27 N. Monroe St. E.L. Phillips F/H Balto., MD. 21217 | | | | 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST CHRONIC RENAL INSUFFICIENCY. AN AEMIA DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/> | | | |
| 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | | | 28a. DATE OF INJURY (Month, Day, Year) 7/10/95 | | | |
| 28b. TIME OF INJURY M | | | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER Surjit A. Jullia | | | | 29c. LICENSE NUMBER 026395 | | | |
| 29d. DATE SIGNED (Month, Day, Year) 7/10/95 | | | | 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) SETON HILL NURSING HOME BALTIMORE MD | | | |
| 31. DATE FILED (Month, Day, Year) JUL 17 1995 | | | | 32. REGISTRAR'S SIGNATURE John D. Tucker-Randall | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 21526

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | | | | | |
|--|--|--|--|--|--|--|--|---|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) <i>ELIZABETH WOMACK</i> | | | | 2. DATE OF DEATH MONTH DAY YEAR <i>July - 10 - 1995</i> | | | | 3. TIME OF DEATH <i>9:15 P.M.</i> | | | | | |
| 4. SOCIAL SECURITY NUMBER <i>215-28-7209</i> | | 5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) <i>64</i> YRS. | | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS. HOURS MIN. | | 7. DATE OF BIRTH (Month, Day, Year) <i>OCT. 30, 1930</i> | | 8. BIRTHPLACE (State or Foreign Country) <i>BALTIMORE, MD</i> | |
| 9a. FACILITY NAME (If not institution, give street and number) <i>LEVINDALE NURSING HOME</i> | | | | | | 9b. CITY, TOWN OR LOCATION OF DEATH <i>BALTIMORE CITY</i> | | | | 9c. COUNTY OF DEATH <i>n/a</i> | | | |
| RESIDENCE OF DECEDENT | | | | | | | | | | | | | |
| 10a. STATE <i>MARYLAND</i> | | 10b. COUNTY <i>n/a</i> | | 10c. CITY, TOWN OR LOCATION <i>BALTIMORE</i> | | | | 10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | | | | |
| 10e. STREET AND NUMBER <i>2434 W. BELVEDERE AVENUE</i> | | | | 10f. ZIP CODE <i>21215</i> | | | | 10g. CITIZEN OF WHAT COUNTRY? <i>UNITED STATES</i> | | | | | |
| 11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES <i>XX</i> | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | | | 14. RACE — American Indian, Black, White, etc. Specify: <i>BLACK</i> | | | | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <i>10 TH</i> College (1-4 or 5+) <i>-</i> | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <i>unemployed</i> | | | | 16b. KIND OF BUSINESS/INDUSTRY <i>none</i> | | | | | |
| 17. FATHER'S NAME (First, Middle, Last) <i>LOUIS WOMACK</i> | | | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) <i>KATE EASLEY</i> | | | | | | | |
| 19a. INFORMANT'S NAME (Type/Print) <i>IRENE QUINCE</i> | | | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>2735 EDMONDSON AVENUE, BALTIMORE, MD 21223</i> | | | | | | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery or place of interment) <i>ARBUTUS MEMORIAL PARK 7-15</i> | | | | 20c. LOCATION — City or Town, State <i>ARBUTUS, MD</i> | | | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Jessie C. Chapman</i> | | | | | | 22. NAME AND ADDRESS OF FACILITY <i>WM. C. MARCH FH.-1101 E. NORTH AVE.</i> | | | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | | | | | | | |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Congestive Heart Failure</i> | | | | | | | | | | | | | |
| DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | | | | | |
| <i>Coronary artery disease</i> | | | | | | | | | | | | | |
| DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | | | | | |
| DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | | | | | |
| DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Severe emphysema</i> <i>Hypoxic encephalopathy</i> | | | | | | | | | | | | | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | | | |
| 27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY <i>M</i> | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED | | | |
| 29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | 29b. SIGNATURE AND TITLE OF CERTIFIER <i>Wlegan M.D.</i> | | | | 29c. LICENSE NUMBER <i>D44817</i> | | 29d. DATE SIGNED (Month, Day, Year) <i>July 10th 1995</i> | | | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>SUNIL P. RAJANI 2434 W Belvedere Ave, Baltimore</i> | | | | | | | | | | | | | |
| 31. DATE FILED (Month, Day, Year) <i>JUL 17 1995</i> | | | | 32. REGISTRAR'S SIGNATURE <i>Julia Anderson</i> | | | | | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

P.O. BOX 68760

DIVISION OF VITAL RECORDS

3

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95.21527

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) BILL Watts | | | | 2. DATE OF DEATH MONTH July DAY 13 YEAR 1995 | | 3. TIME OF DEATH 7:20 A M | |
| 4. SOCIAL SECURITY NUMBER 213 36 3472 | | 5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 71 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 05 05 24 | |
| 9a. FACILITY NAME (If not institution, give street and number) Maryland General Hospital | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Baltimore | | 9c. COUNTY OF DEATH N/A | |
| 10a. STATE Md. | | | | 10b. COUNTY N/A | | 10c. CITY, TOWN OR LOCATION Baltimore | |
| 10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | | | 10e. STREET AND NUMBER 6101 Toone Street | | | |
| 10f. ZIP CODE 21224 | | | | 10g. CITIZEN OF WHAT COUNTRY? USA | | | |
| 11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) Unknown College (13-16) None | | 16. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Laborer | | 17. KIND OF BUSINESS/INDUSTRY Unknown | | | |
| 17. FATHER'S NAME (First, Middle, Last) Brady Watts | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Anna Cross | | | |
| 19a. INFORMANT'S NAME (Type/Print) Pauline Watts | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6101 Toone Street Balto., Md. 21224 | | | |
| 20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Green Mount Crematory 7-15-95 | | 20c. LOCATION — City or Town, State Baltimore, Md. | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Charles S. Zeiler | | | | 22. NAME AND ADDRESS OF FACILITY Charles S. Zeiler & Son Inc. 6224 Eastern Ave. Balto., Md. | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Pneumonia Approximate Interval Between Onset and Death: unknown Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST Acquired Immune Deficiency Syndrome DUE TO (OR AS A CONSEQUENCE OF): Cytomegalovirus Colitis | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Cytomegalovirus Colitis | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO | | | | | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO | |
| 28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28e. DESCRIBE HOW INJURY OCCURRED | | | |
| 29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER Justin Bryne MD | | | | 29c. LICENSE NUMBER 89203 | | 29d. DATE SIGNED (Month, Day, Year) 07/13/95 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Justin Bryne, M.D. c/o Maryland General Hospital | | | | | | | |
| 31. DATE FILED (Month, Day, Year) 11/17/1995 | | 32. REGISTRAR'S SIGNATURE Ali H. H. H. | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 21528

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|---|--|--|---|
| 1. DECEDENT'S NAME (First, Middle, Last) Joseph Edwin Warwick, Jr. | | | | 2. DATE OF DEATH MONTH July DAY 11 YEAR 1995 | | 3. TIME OF DEATH 4:43 PM | |
| 4. SOCIAL SECURITY NUMBER 214-26-4277 | | 5. SEX 1 <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 66 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 1/23/29 | |
| 9a. FACILITY NAME (If not institution, give street and number) Fallston General Hospital | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Rallston | | 9c. COUNTY OF DEATH Harford | |
| 10a. STATE Maryland | | | | 10b. COUNTY Baltimore | | 10c. CITY, TOWN OR LOCATION Towson | |
| 10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | 10e. STREET AND NUMBER 1530 Providence Road | | | |
| 10f. ZIP CODE 21286 | | | | 10g. CITIZEN OF WHAT COUNTRY? USA | | | |
| 11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES WW II | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 2 years | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Contractor | | 16b. KIND OF BUSINESS/INDUSTRY Self Employed | | | |
| 17. FATHER'S NAME (First, Middle, Last) Joseph E. Warwick, Sr. | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Helen H. Hanley | | | |
| 19a. INFORMANT'S NAME (Type/Print) Dorothy K. Warwick | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1530 Providence Road Towson, MD 21286 | | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Dulaney Valley Mem. Gar. 7/15/95 Cockeysville, MD | | 20c. LOCATION — City or Town, State | | 20d. DATE | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | | | | 22. NAME AND ADDRESS OF FACILITY Johnson Funeral Home 8521 Loch Raven Blvd. Towson, MD 21286 | | | |
| 23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | | Acute Myocardial Infarction | | | | | Approximate Interval Between Onset and Death 2 days |
| Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | arteriosclerotic cardiovascular disease | | | | | years |
| | | Cardiomyopathy, ischemic | | | | | years |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Atrial fibrillation Ventricular tachycardia | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/> | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) N/A | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | 28g. DATE SIGNED (Month, Day, Year) July 1995 | | | |
| 29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. SIGNATURE AND TITLE OF CERTIFIER Dean L. Vassar | | 29c. LICENSE NUMBER D16036 | | 29d. DATE SIGNED (Month, Day, Year) July 1995 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Dean L. Vassar, M.D. 104 Plumtree Road, Bel Air, Maryland 21015 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JUL 17 1995 | | 32. REGISTRAR'S SIGNATURE | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 21529

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|---|--|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last) ESTHER A. WILLEY | | | | 2. DATE OF DEATH MONTH July DAY 13 , YEAR 1995 | | 3. TIME OF DEATH 7:30 AM | |
| 4. SOCIAL SECURITY NUMBER 216-74-2214 | | 5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 86 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) June 28, 1909 | |
| 9a. FACILITY NAME (If not institution, give street and number) 600 Knollcrest Pl. #E | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Cockeysville | | 9c. COUNTY OF DEATH Baltimore | |
| 10a. STATE Md. | | | | 10b. COUNTY Baltimore | | 10c. CITY, TOWN OR LOCATION Cockeysville | |
| 10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | 10e. STREET AND NUMBER 600 Knollcrest Pl. #E | | | |
| 10f. ZIP CODE 21030 | | | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | | | |
| 11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 2 College (1-4 or 5+) 2 | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) House Wife | | 16b. KIND OF BUSINESS/INDUSTRY Own Home | | | |
| 17. FATHER'S NAME (First, Middle, Last) Bertram Heinz | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Elsie LaBlanche Dupler | | | |
| 19a. INFORMANT'S NAME (Type/Print) Mr. Frederick J. Willey, Jr. | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 546 Piccadilly Rd. Towson, Md. 21204 | | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Mt. Olivet Cemetery 7/17/95 | | 20c. LOCATION — City or Town, State Baltimore, Md. | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | | | | 22. NAME AND ADDRESS OF FACILITY Ruck Towson Funeral Home, Inc. 1050 York Rd. Towson, Md. 21204 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. ATHEROSCLEROTIC CARDIOVASCULAR Dis b. Hypertension Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST c. d. | | | | | | | Approximate Interval Between Onset and Death |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO | | | | | | | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28d. DESCRIBE HOW INJURY OCCURRED | | | | | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | 28e. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | |
| 29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. SIGNATURE AND TITLE OF CERTIFIER | | 29c. LICENSE NUMBER D20795 | | 29d. DATE SIGNED (Month, Day, Year) 7-14-95 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) John G. Lavin, M.D. 660 Kenilworth Dr. Towson, Md. 21204 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JUL 17 1995 | | 32. REGISTRAR'S SIGNATURE | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

P.O. BOX 68760

DIVISION OF VITAL RECORDS

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 21530

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|--|--|--|--|---|--|
| 1. DECEASED'S NAME (First, Middle, Last) Edith E WAGNER | | | | 2. DATE OF DEATH MONTH DAY YEAR July 14 1995 | | 3. TIME OF DEATH 11:08 PM | |
| 4. SOCIAL SECURITY NUMBER 213-16-6204 | | 5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 78 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 11-5-16 | |
| 8. FACILITY NAME (If not institution, give street and number) Franklin Square Hospital | | | | 9. CITY, TOWN OR LOCATION OF DEATH Rossville | | 10. COUNTY OF DEATH Baltimore | |
| RESIDENCE OF DECEASED | | | | | | | |
| 10a. STATE MD | | 10b. COUNTY Baltimore | | 10c. CITY, TOWN OR LOCATION Essex | | 10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| 10e. STREET AND NUMBER 1929 Silver Lane | | | | 10f. ZIP CODE 21221 | | 10g. CITIZEN OF WHAT COUNTRY? USA | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEASED EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEASED OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: white | |
| 15. DECEASED'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 4 College (1-4 or 5+) 0 | | 16a. DECEASED'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Surgical Supply | | 16b. KIND OF BUSINESS/INDUSTRY Franklin Square Hospital | | | |
| 17. FATHER'S NAME (First, Middle, Last) Carmen Curcio | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Marie (unk.) | | | |
| 19a. INFORMANT'S NAME (Type/Print) Kenneth Wagner | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 227 S. Main St. Shrewsbury, PA 17361 | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Holly Hill Memorial 7-17-95 | | 20c. LOCATION — City or Town, State Middle River, MD | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Denis S. Kelly | | | | 22. NAME AND ADDRESS OF FACILITY Cvach/Rosedale Funeral Home 1211 Chesaco Ave. | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | | a. Congestive heart failure DUE TO (OR AS A CONSEQUENCE OF): | | | | Approximate Interval Between Onset and Death 10 years | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | b. Cardiomyopathy DUE TO (OR AS A CONSEQUENCE OF): | | | | 10 years | |
| | | c. DUE TO (OR AS A CONSEQUENCE OF): | | | | | |
| | | d. DUE TO (OR AS A CONSEQUENCE OF): | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Chronic obstructive pulmonary disease, history of transient ischemic attack, history of paralyzed left diaphragm DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 28d. DESCRIBE NOW INJURY OCCURRED | | | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER Karen Moffett MD. | | | | 29c. LICENSE NUMBER R D 001784 | | 29d. DATE SIGNED (Month, Day, Year) July 14, 1995 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Dr. Karen Moffett MD 9000 Franklin Square Drive Baltimore Maryland 21237-3998 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JUL 17 1995 | | | | 32. REGISTRAR'S SIGNATURE John A. ... | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 21531

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) ALVIN A ASHLEY | | | | 2. DATE OF DEATH MONTH JULY DAY 03 YEAR 1995 | | 3. TIME OF DEATH 8:35 P.M. | |
| 4. SOCIAL SECURITY NUMBER 212-28-9590 | | 5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 62 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 10/17/32 | |
| 9a. FACILITY NAME (If not institution, give street and number) University of Maryland | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Baltimore | | 9c. COUNTY OF DEATH Baltimore | |
| 10a. STATE Maryland | | | | 10b. COUNTY Baltimore | | 10c. CITY, TOWN OR LOCATION Baltimore | |
| 10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | | | | | | |
| 10e. STREET AND NUMBER 3607 Mohawk Avenue | | | | 10f. ZIP CODE 21207 | | 10g. CITIZEN OF WHAT COUNTRY? USA | |
| 11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: Black | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Truck Driver | | 16b. KIND OF BUSINESS/INDUSTRY Unknown | | | |
| 17. FATHER'S NAME (First, Middle, Last) Frank Ashley | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Alice Mitchell | | | |
| 19a. INFORMANT'S NAME (Type/Print) Robert Ashley | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7102 Marston Road Balto. Md. 21207 | | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Mt. Zion | | DATE 7/8/95 | | 20c. LOCATION — City or Town, State Landsdown Md. | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE JWE Howell | | | | 22. NAME AND ADDRESS OF FACILITY Unity Funeral Home 108 W. North Avenue | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. SEPSIS DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO | | | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/> | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO | |
| 28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28e. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER: Bruce McShane | | | | 29c. LICENSE NUMBER D46884 | | 29d. DATE SIGNED (Month, Day, Year) 7/11/95 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 22 S Greene St Baltimore MD 21201 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JUL 18 1995 | | 32. REGISTRAR'S SIGNATURE Johanna K. K. K. | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) <u>Melvin Boyd-Sr</u> | | | | 2. DATE OF DEATH MONTH <u>JULY</u> DAY <u>16</u> YEAR <u>1995</u> | | 3. TIME OF DEATH <u>2053 P M</u> | |
| 4. SOCIAL SECURITY NUMBER <u>212-30-9304</u> | | 5. SEX <u>1</u> <input checked="" type="checkbox"/> M <input type="checkbox"/> F | 6. AGE (In yrs. last birthday) <u>63</u> YRS. | IF UNDER 1 YEAR MONTHS <u> </u> DAYS <u> </u> | IF UNDER 24 HRS. HOURS <u> </u> MIN. <u> </u> | 7. DATE OF BIRTH (Month, Day, Year) <u>JUN. 1, 1932</u> | |
| 8. BIRTHPLACE (State or Foreign Country) <u>BALTIMORE, MD</u> | | | | 9a. FACILITY NAME (If not institution, give street and number) <u>Union Memorial Hosp</u> | | 9b. CITY, TOWN OR LOCATION OF DEATH <u>Balto City</u> | |
| 9c. COUNTY OF DEATH <u>n/a</u> | | | | 10a. STATE <u>MARYLAND</u> | | 10b. COUNTY <u>n/a</u> | |
| 10c. CITY, TOWN OR LOCATION <u>BALTIMORE</u> | | | | 10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | 10e. STREET AND NUMBER <u>2007 WOODBOURNE AVENUE</u> | |
| 10f. ZIP CODE <u>21239</u> | | | | 10g. CITIZEN OF WHAT COUNTRY? <u>UNITED STATES</u> | | 11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES <u>n/a ARMY</u> | | | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: <u> </u> | | 14. RACE — American Indian, Black, White, etc. Specify: <u>BLACK</u> | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (10-12) <u>10 TH</u> College (1-4 or 5+) <u> </u> | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <u>LABORER</u> | | 16b. KIND OF BUSINESS/INDUSTRY <u>BETHLEHEM STEEL INDUSTRY</u> | |
| 17. FATHER'S NAME (First, Middle, Last) <u>HENRY BOYD</u> | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) <u>CHEEKS</u> | | | |
| 19a. INFORMANT'S NAME (Type/Print) <u>REV. LILLIAN BOYD</u> | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>2007 WOODBOURNE AVENUE, BALTIMORE, MD 21239</u> | | | |
| 20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) <u> </u> | | | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <u>GARRISON FOREST VA CEM. 7-21-95 OWINGS MILLS, MD</u> | | 20c. LOCATION — City or Town, State | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <u>Wm. C. March</u> | | | | 22. NAME AND ADDRESS OF FACILITY <u>WM. C. MARCH FH.-1101 E. NORTH AVENUE</u> | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <u>CEREBRAL VASCULAR ACCIDENT</u> DUE TO (OR AS A CONSEQUENCE OF): b. <u>HYPERTENSION</u> DUE TO (OR AS A CONSEQUENCE OF): c. <u>CORONARY ARTERY DISEASE</u> DUE TO (OR AS A CONSEQUENCE OF): d. <u> </u> Approximate Interval Between Onset and Death <u>10 DAYS</u> <u>10 years</u> <u>10 years</u> | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u> </u> | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) <u> </u> | | | | | |
| 27. MANNER OF DEATH 1. <input checked="" type="checkbox"/> Natural 5. <input type="checkbox"/> Pending Investigation 2. <input type="checkbox"/> Accident 6. <input type="checkbox"/> Could not be determined 3. <input type="checkbox"/> Suicide 8. <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M <u> </u> | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28e. DESCRIBE HOW INJURY OCCURRED | | | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | 28g. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one) 1. <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER <u>Theresa E. Hanley D.O.</u> HANLEY D.O. | | | | 29c. LICENSE NUMBER <u>AT 2438946</u> | | 29d. DATE SIGNED (Month, Day, Year) <u>JULY 16, 1995</u> | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <u>MARY ELIZABETH HANLEY, D.O. 201 E. UNIVERSITY PKWY. BALTIMORE, MD 21218</u> | | | | | | | |
| 31. DATE FILED (Month, Day, Year) <u>JUL 18 1995</u> | | | | 32. REGISTRAR'S SIGNATURE <u>John D. ...</u> | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

P.O. BOX 68760

DIVISION OF VITAL RECORDS

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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1 -
FOR
STATE
REGISTRARSTATE OF MARYLAND & DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | |
|--|--|---|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) L. THOMAS BOWMAN | | | | 2. DATE OF DEATH MONTH JULY DAY 12 YEAR 1995 | | 3. TIME OF DEATH 16:20 P.M. | | | |
| 4. SOCIAL SECURITY NUMBER 215-46-7716 | | 5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 48 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 2-19-46 | | 8. BIRTHPLACE (State or Foreign Country) Maryland | |
| 9a. FACILITY NAME (If not institution, give street and number) UNION MEMORIAL HOSPITAL | | | | 9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE CITY | | | | 9c. COUNTY OF DEATH None | |
| 10a. STATE Maryland | | 10b. COUNTY None | | 10c. CITY, TOWN OR LOCATION Baltimore | | | | 10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | |
| 10e. STREET AND NUMBER 444 E. 22nd St. | | | | 10f. ZIP CODE 21218 | | 10g. CITIZEN OF WHAT COUNTRY? USA | | | |
| 11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES 4/1/66 - 3/31/68 | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: Black | | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Pest Control | | 16b. KIND OF BUSINESS/INDUSTRY City | | | | | |
| 17. FATHER'S NAME (First, Middle, Last) Henderson Leroy Bowman | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Annie B. Claiborne | | | | | |
| 19a. INFORMANT'S NAME (Type/Print) Phyllis Askew | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 444 E. 22nd St. Balto., Md. 21218 | | | | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Garrison Forest | | DATE 7/19 | | 20c. LOCATION — City or Town, State Owings Mill, Md. | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Derrick C. Jones</i> | | | | 22. NAME AND ADDRESS OF FACILITY Derrick C. Jones Funeral Home 4611 Park Heights Ave. | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → INFECTIVE ENDOCARDITIS Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): Approximate interval Between Onset and Death 15 DAYS | | | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ENCEPHALOPATHY; ARDS; RENAL FAILURE | | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | | | | | | | | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | |
| 27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED | |
| | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER <i>Charles C. Brown, M.D. Assoc. Pathologist</i> | | | | 29c. LICENSE NUMBER D01008 | | 29d. DATE SIGNED (Month, Day, Year) JULY 14, 1995 | | | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) CHARLES C. BROWN, M.D. 201 E. UNIVERSITY PARKWAY BALTIMORE-21218 | | | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JUL 18 1995 | | 32. REGISTRAR'S SIGNATURE <i>John D. ...</i> | | | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 21534

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|---|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) RUTH ANNA BLOTTENBERGER | | | | 2. DATE OF DEATH MONTH JULY DAY 13 YEAR 1995 | | 3. TIME OF DEATH 12:45 PM | |
| 4. SOCIAL SECURITY NUMBER 212-30-0192 | | 5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 8. AGE (In yrs. last birthday) 63 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 04-08-1932 | |
| 9a. FACILITY NAME (If not institution, give street and number) 1205 SOMERSET ROAD | | | | 9b. CITY, TOWN OR LOCATION OF DEATH SEVERN | | 9c. COUNTY OF DEATH ANNE ARUNDEL | |
| 10a. STATE MARYLAND | | 10b. COUNTY ANNE ARUNDEL | | 10c. CITY, TOWN OR LOCATION SEVERN | | 10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| 10e. STREET AND NUMBER 1205 SOMERSET ROAD | | | | 10f. ZIP CODE 21144 | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: WHITE | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (8-12) 12 College (1-4 or 5+) N/A | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) HOMEMAKER | | 16b. KIND OF BUSINESS/INDUSTRY OWN HOME | | | |
| 17. FATHER'S NAME (First, Middle, Last) EDWARD EMORY CLARK | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) EDNA JOSEPH BROOKS | | | |
| 19a. INFORMANT'S NAME (Type/Print) WILLIAM CLARENCE BLOTTENBERGER | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1205 SOMERSET ROAD, SEVERN, MARYLAND 21144 | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 6 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) GLEN HAVEN MEMORIAL PARK 7/17/95 | | 20c. LOCATION — City or Town, State GLEN BURNIE, MARYLAND | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Michael C. Safford</i> | | | | 22. NAME AND ADDRESS OF FACILITY SINGLETON FUNERAL HOME 1 SECOND AVENUE, S.W., GLEN BURNIE, MD. 21061 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → metastatic breast cancer DUE TO (OR AS A CONSEQUENCE OF): Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER <i>Ann W. Beckman MD</i> | | | | 29c. LICENSE NUMBER 022782 | | 29d. DATE SIGNED (Month, Day, Year) 7/14/95 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Ann W. Beckman MD Harbor Hospital Center | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JUL 18 1995 | | 32. REGISTRAR'S SIGNATURE <i>John D. Buckner-Randall</i> | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 -
FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|---|--|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last) ETHEL A BOWSER | | | | 2. DATE OF DEATH MONTH JULY DAY 14 YEAR 1995 | | 3. TIME OF DEATH 9:48 P M | |
| 4. SOCIAL SECURITY NUMBER 22 0 22 7578 | | 5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 67 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) February 12, 1928 Maryland | |
| 9a. FACILITY NAME (If not institution, give street and number) Good Samaritan Hospital | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Baltimore | | 9c. COUNTY OF DEATH N/A | |
| 10a. STATE Maryland | | | | 10b. COUNTY Baltimore | | 10c. CITY, TOWN OR LOCATION Baltimore | |
| 10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | | | 10e. STREET AND NUMBER 5602 Lothian Road | | | |
| 10f. ZIP CODE 21212 | | | | 10g. CITIZEN OF WHAT COUNTRY? USA | | | |
| 11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: Black | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) Domestic 12TH | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Domestic | | 16b. KIND OF BUSINESS/INDUSTRY Private Family | | | |
| 17. FATHER'S NAME (First, Middle, Last) John Frazier | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Hester Johnson | | | |
| 19a. INFORMANT'S NAME (Type/Print) Gloria Wyatt | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3225 Northway Dr. Baltimore, Maryland 21234 | | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Pleasant Rest Cemetery 7/20 | | 20c. LOCATION — City or Town, State Towson, Maryland | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i> | | | | 22. NAME AND ADDRESS OF FACILITY Nutter Funeral Homes Inc. 2501 Gwynn Falls Parkway Baltimore, Md. 21216 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. SEPSIS DUE TO (OR AS A CONSEQUENCE OF): b. END STAGE RENAL DISEASE DUE TO (OR AS A CONSEQUENCE OF): c. RESPIRATORY FAILURE DUE TO (OR AS A CONSEQUENCE OF): d. Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST | | | | | | | Approximate Interval Between Onset and Death 48 hours |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | | | | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/> | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i> M.D. | | | | 29c. LICENSE NUMBER P 08241 | | 29d. DATE SIGNED (Month, Day, Year) JULY 14, 1995 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) SANJAY SETHI, GOOD SAMARITAN HOSPITAL, 5601 LOCH RAVEN BLVD, BALTIMORE 21239 MD | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JUL 18 1995 | | 32. REGISTRAR'S SIGNATURE <i>[Signature]</i> | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

P.O. BOX 68760

4

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Pleasant Res

2

Wm. H. H. H.

95 21536

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) <i>Evelyn Burrell</i> | | | | 2. DATE OF DEATH MONTH <i>July</i> DAY <i>15</i> YEAR <i>1995</i> | | 3. TIME OF DEATH <i>6:00 A.M.</i> | |
| 4. SOCIAL SECURITY NUMBER <i>212-01-6123</i> | | 5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) <i>78</i> YRS. | | 7. DATE OF BIRTH (Month, Day, Year) <i>October 16, 1916</i> | |
| 8a. FACILITY NAME (If not institution, give street and number) <i>Levindale Geriatric Center</i> | | | | 8b. CITY, TOWN OR LOCATION OF DEATH <i>Baltimore</i> | | 8c. COUNTY OF DEATH <i>N/A</i> | |
| RESIDENCE OF DECEDENT | | | | | | | |
| 10a. STATE <i>Maryland</i> | | 10b. COUNTY | | 10c. CITY, TOWN OR LOCATION <i>Baltimore</i> | | 10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | |
| 10e. STREET AND NUMBER <i>7410 Castlemoor Road</i> | | | | 10f. ZIP CODE <i>21244</i> | | 10g. CITIZEN OF WHAT COUNTRY? <i>USA</i> | |
| 11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: <i>Black</i> | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <i>High School Grad 8-Yrs</i> | | 15b. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <i>Teacher</i> | | 15c. KIND OF BUSINESS/INDUSTRY <i>University of Maryland</i> | | | |
| 17. FATHER'S NAME (First, Middle, Last) <i>John W. Patterson</i> | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) <i>Grace Johnson</i> | | | |
| 19a. INFORMANT'S NAME (Type/Print) <i>David Allen</i> | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>10608 High Beam Ct. Columbia, Maryland 21044</i> | | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input checked="" type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <i>Maryland National Park 7/22</i> | | 20c. LOCATION — City or Town, State <i>Laurel, Maryland</i> | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Gary A. Hollens</i> | | | | 22. NAME AND ADDRESS OF FACILITY <i>Nutters Funeral Home 2501 Gwynn Falls Parkway Baltimore, Maryland 21216</i> | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>acute - cardio pulmonary arrest</i> DUE TO (OR AS A CONSEQUENCE OF): a. <i>atherosclerotic heart disease</i> DUE TO (OR AS A CONSEQUENCE OF): b. <i>congestive heart failure</i> DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | | Approximate Interval Between Onset and Death |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>decubiti - scarred multi infarct dementia s/p cerebrovascular accident malnutrition</i> | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/> | | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY <i>M</i> | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | 28g. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER <i>Consuelo Murray MD</i> | | | | 29c. LICENSE NUMBER <i>D-44907</i> | | 29d. DATE SIGNED (Month, Day, Year) <i>July 15th 1995</i> | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>Consuelo Murray MD 2434 W. Belvedere Ave Baltimore, MD 21215</i> | | | | | | | |
| 31. DATE FILED (Month, Day, Year) <i>JUL 18 1995</i> | | | | 32. SIGNATURE OF REGISTRAR <i>John A. ...</i> | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 21537

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|--|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) LOWELL BAILEY Lowell Thomas Bailey | | | | 2. DATE OF DEATH MONTH DAY YEAR July 13 1995 | | 3. TIME OF DEATH 4:55 p. M | |
| 4. SOCIAL SECURITY NUMBER 233-44-7901 | | 5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 63 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 08/10/31 | |
| 8. BIRTHPLACE (State or Foreign Country) Leckie, W. Va. | | | | 9a. FACILITY NAME (If not institution, give street and number) Fort Howard VAMC | | 9b. CITY, TOWN OR LOCATION OF DEATH Ft. Howard | |
| 9c. COUNTY OF DEATH Baltimore | | | | 10a. STATE Maryland | | 10b. COUNTY Baltimore | |
| 10c. CITY, TOWN OR LOCATION Baltimore | | | | 10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 10e. STREET AND NUMBER 1118 Seneca Road | |
| 10f. ZIP CODE 21220 | | | | 10g. CITIZEN OF WHAT COUNTRY? USA | | 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced | |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) "Unknown" College (1-4 or 5+) | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Merchant Marine | | 16b. KIND OF BUSINESS/INDUSTRY Shipping Industry | |
| 17. FATHER'S NAME (First, Middle, Last) Walter Everette Bailey | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Minnie Catherine Lovelace | | | |
| 19a. INFORMANT'S NAME (Type/Print) Dianne Susan Farmer | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1118 Seneca Rd. Baltimore, MD 21220 | | | |
| 20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE AND DATE OF DISPOSITION (Name of facility, street, city, state, zip code) Metro Crematory, Inc. 07/14/95 | | 20c. LOCATION — City or Town, State Baltimore, MD | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Dawn F. McDonald | | | | 22. NAME AND ADDRESS OF FACILITY Cremation Society of Maryland, Inc. 299 Frederick Rd. Baltimore, MD 21228 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <u>TERMINAL CANCER OF LUNGS</u> DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Approximate Interval Between Onset and Death DAYS | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>AORTIC THROMBOSIS, HX OF CANCER OF LARYNX</u> | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide 3 <input type="checkbox"/> Homicide 7 <input type="checkbox"/> Could not be determined | | | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | |
| 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | 28d. DESCRIBE HOW INJURY OCCURRED | | | |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER John B. ... | | | | 29c. LICENSE NUMBER D 15628 | | 29d. DATE SIGNED (Month, Day, Year) 7/13/95 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) DR. CUSTODIO, CAROLINA M.D. 9600 NORTH POINT ROAD, FORT HOWARD, MARYLAND 21052 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JUL 18 1995 | | | | 32. REGISTRAR'S SIGNATURE John ... | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 21538

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) ANN H. BLUMBERG | | | | 2. DATE OF DEATH MONTH DAY YEAR JULY 12, 1995 | | 3. TIME OF DEATH 8 pm M | |
| 4. SOCIAL SECURITY NUMBER 217-16-8981 | | 5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 71 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) DEC. 13, 1923 | |
| 9a. FACILITY NAME (If not institution, give street and number) 7608 DANIELS AVENUE | | | | 9b. CITY, TOWN OR LOCATION OF DEATH PARKVILLE | | 9c. COUNTY OF DEATH BALTIMORE | |
| RESIDENCE OF DECEDENT | | | | | | | |
| 10a. STATE MARYLAND | | 10b. COUNTY BALTIMORE | | 10c. CITY, TOWN OR LOCATION PARKVILLE | | 10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 10e. STREET AND NUMBER 7608 DANIELS AVENUE | | | | 10f. ZIP CODE 21234 | | 10g. CITIZEN OF WHAT COUNTRY? USA | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR DR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: WHITE | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 8 | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) HOUSEWIFE | | 16b. KIND OF BUSINESS/INDUSTRY OWN HOME | | | |
| 17. FATHER'S NAME (First, Middle, Last) UNKNOWN SCHERR | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) SARAH UNKNOWN | | | |
| 19a. INFORMANT'S NAME (Type/Print) MRS. DEBORAH KING | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7608 DANIELS AVENUE PARKVILLE, MD 21234 | | | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) ANSHE EMUNAH (AITZ CHAIM) 7-14-1995 BALTIMORE, MD | | 20c. LOCATION — City or Town, State | | 20d. DATE | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i> | | | | 22. NAME AND ADDRESS OF FACILITY SOL LEVINSON & BROS., INC. 6010 REISTERSTOWN ROAD BALTIMORE, MD 21215 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <u>Ovarian Carcinoma</u> DUE TO (OR AS A CONSEQUENCE OF): Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. _____ DUE TO (OR AS A CONSEQUENCE OF): c. _____ DUE TO (OR AS A CONSEQUENCE OF): d. _____ | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | 28g. DATE OF INJURY | | | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER Matilda H. So, MD | | | | 29c. LICENSE NUMBER D26250 | | 29d. DATE SIGNED (Month, Day, Year) 7/13/95 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) MATILDA H. SO, 1447 YORK ROAD, LUTHERVILLE, MD. 21093. | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JUL 18 1995 | | | | REGISTRAR'S SIGNATURE <i>[Signature]</i> | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) <i>Stanley P. Barrash</i> Stanley P. Barrash | | | | 2. DATE OF DEATH MONTH DAY YEAR <i>July 12 1995</i> | | 3. TIME OF DEATH <i>1:50 A.M.</i> | |
| 4. SOCIAL SECURITY NUMBER 212-26-0579 | | 5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 67 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) JAN. 7, 1928 | |
| 8. FACILITY NAME (If not institution, give street and number) SINAI HOSPITAL | | | | 9. CITY, TOWN OR LOCATION OF DEATH BALTIMORE | | 10. COUNTY OF DEATH N/A | |
| 11. STATE MARYLAND | | | | 12. COUNTY BALTIMORE | | 13. CITY, TOWN OR LOCATION BALTIMORE | |
| 14. STREET AND NUMBER 7202 ROCKLAND HILLS DR. APT. 108 | | | | 15. ZIP CODE 21209 | | 16. CITIZEN OF WHAT COUNTRY? USA | |
| 17. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 18. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 19. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 20. RACE — American Indian, Black, White, etc. Specify: WHITE | |
| 21. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 4 | | 22. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) OWNER | | 23. KIND OF BUSINESS/INDUSTRY BRIDAL SHOP | | | |
| 24. FATHER'S NAME (First, Middle, Last) FRANK BARRASH | | | | 25. MOTHER'S NAME (First, Middle, Maiden Surname) ETTA MERKEL | | | |
| 26. INFORMANT'S NAME (Type/Print) MRS. SHIRLEY BARRASH | | | | 27. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7202 ROCKLAND HILLS DR., APT. 108 BALTO., MD 21208 | | | |
| 28. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 29. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) MOGAN ABRAHAM 7/13/95 | | 30. DATE 7/13/95 | | 31. LOCATION — City or Town, State ROSEDALE, MD | |
| 32. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Gay O'Keefe</i> | | | | 33. NAME AND ADDRESS OF FACILITY SOL LEVINSON & BROS., INC. 6010 REISTERTOWN RD. BALTO., MD 21215 | | | |
| 34. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Gastric Carcinoma</i> DUE TO (OR AS A CONSEQUENCE OF): Approximate Interval Between Onset and Death <i>3 weeks</i> | | | | | | | |
| 35. Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| 36. PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | |
| 37. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | 38. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 39. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO | |
| 40. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | 41. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 42. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | 43. DATE OF INJURY (Month, Day, Year) | | 44. TIME OF INJURY M | | 45. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 46. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 47. DESCRIBE HOW INJURY OCCURRED | | | | | |
| 48. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | 49. DATE SIGNED (Month, Day, Year) <i>July 14, 1995</i> | | | | | |
| 50. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <i>Michelle L. ... M.D.</i> 29. SIGNATURE AND TITLE OF CERTIFIER <i>Michelle L. ...</i> 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>3030 Abell Avenue Baltimore MD 21218</i> | | | | 51. LICENSE NUMBER AT4147357 | | 52. DATE SIGNED (Month, Day, Year) <i>July 14, 1995</i> | |
| 53. DATE FILED (Month, Day, Year) JUL 18 1995 | | 54. REGISTRAR'S SIGNATURE <i>Julia Anderson-Rodell</i> | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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Handwritten text at the top right, possibly a title or header.

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Handwritten text at the bottom of the page, possibly a signature or conclusion.

95 21540

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) William G. Barlow | | | | 2. DATE OF DEATH MONTH DAY YEAR July 15, 1995 | | 3. TIME OF DEATH 2:50pm M | |
| 4. SOCIAL SECURITY NUMBER 207-28-0396 | | 5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 65 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) Oct. 10, 1929 | |
| 9a. FACILITY NAME (If not institution, give street and number) 1000 Franklin Ave. | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Essex | | 9c. COUNTY OF DEATH Baltimore | |
| 10a. STATE Md. | | | | 10b. COUNTY Baltimore | | 10c. CITY, TOWN OR LOCATION Essex | |
| 10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | | | | |
| 10e. STREET AND NUMBER 1000 Franklin Ave. Apt. 917 | | | | 10f. ZIP CODE 21221 | | 10g. CITIZEN OF WHAT COUNTRY? USA | |
| 11. MARITAL STATUS 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 4yrs | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Bartender | | 16b. KIND OF BUSINESS/INDUSTRY n/a | | | |
| 17. FATHER'S NAME (First, Middle, Last) Stephen Barlow | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Anna Kevel | | | |
| 19a. INFORMANT'S NAME (Type/Print) Anne McGinley | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 421 Burns Drive Springfield PA. 19064 | | | |
| 20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Metro Crematory Inc. 7/17/95 | | 20c. LOCATION — City or Town, State Baltimore Md. | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE R. Terry Connelly | | | | 22. NAME AND ADDRESS OF FACILITY Connelly Funeral Home of Essex 300 Mace Ave. Baltimore Md. 21221 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Chronic ischemic myocardial disease IMMEDIATE CAUSE (Final disease or condition resulting in death) → Sequitely flat conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST a. DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. | | | | Approximate Interval Between Onset and Death | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 6 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| 29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER J. Crossan Donovan, M.D. | | | | 29c. LICENSE NUMBER D07632 | | 29d. DATE SIGNED (Month, Day, Year) 7-17-95 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) J. Crossan Donovan, M.D., 2112 Dundalk Ave., Balto MD 21222 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JUL 18 1995 | | | | 32. REGISTRAR'S SIGNATURE John Davidson-Randall | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

P.O. BOX 68760

6

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 21541

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) <i>Julie C. Bunce</i> | | | | 2. DATE OF DEATH MONTH DAY YEAR <i>July 11 1995</i> | | 3. TIME OF DEATH <i>1:29 a m</i> | |
| 4. SOCIAL SECURITY NUMBER <i>217-94-8619</i> | | 5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) <i>32</i> YRS. | | 7. DATE OF BIRTH (Month, Day, Year) <i>Mar. 18, 1963</i> | |
| 9a. FACILITY NAME (If not institution, give street and number) <i>University of Md. Hospital</i> | | | | 9b. CITY, TOWN OR LOCATION OF DEATH <i>Baltimore</i> | | 9c. COUNTY OF DEATH <i>Baltimore City</i> | |
| 10a. STATE <i>Maryland</i> | | | | 10b. COUNTY <i>Baltimore City</i> | | 10c. CITY, TOWN OR LOCATION <i>Baltimore City</i> | |
| 10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | | | 10e. STREET AND NUMBER <i>4122 Townsend Avenue</i> | | | |
| 10f. ZIP CODE <i>21225</i> | | | | 10g. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i> | | | |
| 11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: <i>White</i> | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) <i>Elementary/Secondary (0-12) 12</i> | | 15b. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <i>Fitness Trainer</i> | | 16b. KIND OF BUSINESS/INDUSTRY <i>Sinai Fitness</i> | | | |
| 17. FATHER'S NAME (First, Middle, Last) <i>Leonard V. Bunce</i> | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) <i>Carolyn B. Snyder</i> | | | |
| 19a. INFORMANT'S NAME (Type/Print) <i>Leonard V. Bunce</i> | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>4122 Townsend Ave. Baltimore, Md. 21225</i> | | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <i>BelAir Memorial Grds. 7/13/95</i> | | 20c. LOCATION — City or Town, State <i>BelAir, Maryland</i> | | 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>E. F. Lassahn</i> | |
| 22. NAME AND ADDRESS OF FACILITY <i>E. F. Lassahn Funeral Home</i> | | 22b. ADDRESS OF FACILITY <i>11750 Belair Road Kingsville, Md. 21087</i> | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | | | | | | | |
| a. <i>Fulminant Hepatic Failure</i> DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| b. <i>Chronic Active Hepatitis C</i> DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| c. <i>Systemic Lupus Erythematosus</i> DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| d. | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | | | | |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | | | | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY <i>M</i> | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29a. SIGNATURE AND TITLE OF CERTIFIER <i>Rochelle Cunningham</i> | | | | 29c. LICENSE NUMBER <i>7770</i> | | 29d. DATE SIGNED (Month, Day, Year) <i>July 11, 1995</i> | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>Rochelle Cunningham 22 South Greene St. BALTIMORE, MD 20201</i> | | | | | | | |
| 31. DATE FILED (Month, Day, Year) <i>JUL 18 1995</i> | | | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

P.O. BOX 68760

10

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 21542

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | | |
|--|--|--|-------------|---|--|--|--|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) Betty Barkins Brown | | | | | | 2. DATE OF DEATH MONTH 7 DAY 11 YEAR 95 | | 3. TIME OF DEATH 7 30 A M | | |
| 4. SOCIAL SECURITY NUMBER 219-40-8423 | | 5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 52 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 4 14 43 | | 8. BIRTHPLACE (State or Foreign Country) | | |
| 9a. FACILITY NAME (If not institution, give street and number) Seton Hill Manor | | | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Baltimore city | | 9c. COUNTY OF DEATH | | |
| RESIDENCE OF DECEDENT | | | | | | | | | | |
| 10a. STATE Maryland | | | 10b. COUNTY | | | 10c. CITY, TOWN OR LOCATION Baltimore | | | 10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 10e. STREET AND NUMBER 827 N. Arlington Avenue | | | | | | 10f. ZIP CODE 21217 | | 10g. CITIZEN OF WHAT COUNTRY? | | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: Black | | | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) | | 16b. KIND OF BUSINESS/INDUSTRY | | | | |
| 17. FATHER'S NAME (First, Middle, Last) | | | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) | | | | |
| 19a. INFORMANT'S NAME (Type/Print) Howard Brown | | | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 827 N. Arlington Avenue, Baltimore, MD. 21217 | | | | |
| 20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) in state removal | | | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) | | DATE | | 20c. LOCATION — City or Town, State | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Ronald Wade, Dir. <i>[Signature]</i> | | | | | | 22. NAME AND ADDRESS OF FACILITY State Anatomy Board 655 W. Baltimore St., Baltimore, MD. 21201 | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Disseminated Esophageal Carcinoma Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. | | | | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. HIV INFECTION | | | | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 8 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | | | 28d. DESCRIBE HOW INJURY OCCURRED | | | | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | | 28g. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i> | | | | | | 29c. LICENSE NUMBER D39771 | | 29d. DATE SIGNED (Month, Day, Year) 7-11-95 | | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) DAVID WHEELER 29 S. GREEN ST Room 226 Baltimore, MD 21201 | | | | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JUL 17 1995 | | 32. REGISTRAR'S SIGNATURE <i>[Signature]</i> | | | | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|---|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) JOAN ANN CARR | | | | 2. DATE OF DEATH MONTH DAY YEAR JULY 15, 1995 | | 3. TIME OF DEATH 12:35 a m | |
| 4. SOCIAL SECURITY NUMBER 216-34-5782 | | 5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 55 YRS. | | 7. DATE OF BIRTH MONTH DAY YEAR JAN. 30, 1940 | |
| 8. BIRTHPLACE (State or Foreign Country) MARYLAND | | | | 9. FACILITY NAME (If not institution, give street and number) 638 E. 29 TH STREET | | 10. CITY, TOWN OR LOCATION OF DEATH BALTIMORE CITY | |
| 11. COUNTY OF DEATH n/a | | | | 12. RESIDENCE OF DECEDENT | | | |
| 10a. STATE MARYLAND | | 10b. COUNTY n/a | | 10c. CITY, TOWN OR LOCATION BALTIMORE | | 10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | |
| 10e. STREET AND NUMBER 638 E. 29 TH STREET | | | | 10f. ZIP CODE 21218 | | 10g. CITIZEN OF WHAT COUNTRY? UNITED STATES | |
| 11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: BLACK | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 10 th College (1-4 or 5+) — | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) COOK | | 16b. KIND OF BUSINESS/INDUSTRY JOHNS HOPKINS HOSPITAL | | | |
| 17. FATHER'S NAME (First, Middle, Last) TROY GILMORE CARR | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) EMMA YOUNG | | | |
| 19a. INFORMANT'S NAME (Type/Print) LINDA HARRIS | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 107 CARRAWAY ROAD APT. 213, REISTERSTOWN, MD 21136 | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) KING MEMORIAL PARK 7-20 | | 20c. LOCATION — City or Town, State RANDALLSTOWN, MD | | 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Spittle K. Jones</i> | |
| 22. NAME AND ADDRESS OF FACILITY WM. C. MARCH FH.-1101 E. NORTH AVENUE | | | | 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. METASTATIC LUNG CARCINOMA DUE TO (OR AS A CONSEQUENCE OF): b. HYPERTENSION DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER <i>MD PhD</i> | | | | 29c. LICENSE NUMBER A46104 | | 29d. DATE SIGNED (Month, Day, Year) 7/18/95 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) ROBERT ORLOWSKI 600 N. WALKE ST BALTIMORE, MD 21207 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JUL 18 1995 | | | | 32. REGISTRAR'S SIGNATURE <i>John Davidson-Russell</i> | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 21544

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|---|---|--------------------------------|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) Marie M. Clay | | | | 2. DATE OF DEATH MONTH DAY YEAR July 12, 1995 | | 3. TIME OF DEATH 9:25 P.M. | |
| 4. SOCIAL SECURITY NUMBER 212-14-8998 | | 5. SEX A <input type="checkbox"/> M <input checked="" type="checkbox"/> F | 6. AGE (In yrs. last birthday) 90 YRS. | IF UNDER 1 YEAR MONTHS DAYS | IF UNDER 24 HRS. HOURS MIN. | 7. DATE OF BIRTH (Month, Day, Year) Aug. 4, 1904 | |
| 8. BIRTHPLACE (State or Foreign Country) Arkansas | | | | 9a. FACILITY NAME (If not institution, give street and number) Meridian Nursing Home- Homewood | | 9b. CITY, TOWN OR LOCATION OF DEATH Baltimore City | |
| 9c. COUNTY OF DEATH n/a | | | | RESIDENCE OF DECEDENT | | | |
| 10a. STATE Maryland | | 10b. COUNTY n/a | | 10c. CITY, TOWN OR LOCATION Baltimore | | 10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | |
| 10e. STREET AND NUMBER 324 E. 23 rd Street | | | | 10f. ZIP CODE 21218 | | 10g. CITIZEN OF WHAT COUNTRY? United States | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: Black | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) unknown - | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Beautician | | 16b. KIND OF BUSINESS/INDUSTRY Cosmetology | | | |
| 17. FATHER'S NAME (First, Middle, Last) William Braxton | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Carry | | | |
| 19a. INFORMANT'S NAME (Type/Print) Elaine Hairston | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1027 N. Central Avenue, Baltimore, MD 21202 | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Cedar Hill Cemetery 7-17 | | 20c. LOCATION — City or Town, State Anne Arundel Co, MD | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | | | | 22. NAME AND ADDRESS OF FACILITY WM. C. March fh.-1101 E. NORTH AVENUE | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | | a. <u>Aspiration pneumonia</u> DUE TO (OR AS A CONSEQUENCE OF): | | | | Approximate Interval Between Onset and Death 1 | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | b. <u>dementia</u> DUE TO (OR AS A CONSEQUENCE OF): | | | | 5 yrs. | |
| | | c. DUE TO (OR AS A CONSEQUENCE OF): | | | | | |
| | | d. DUE TO (OR AS A CONSEQUENCE OF): | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>Metastatic Breast CA</u> | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| | | 28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28e. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. SIGNATURE AND TITLE OF CERTIFIER physician | | 29c. LICENSE NUMBER D28987 | | 29d. DATE SIGNED (Month, Day, Year) 7-17-95 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) CARL SPERLING, M.D. 5601 LOCH RAVEN BLVD BALD, MD 21239 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JUL 18 1995 | | 32. REGISTRAR'S SIGNATURE | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95-4116-510
blh

95-169

95 21545

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | | | |
|---|--|--|--|---|--|---|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) KEVIN CARTER | | | | 2. DATE OF DEATH MONTH DAY YEAR July 15 1995 | | 3. TIME OF DEATH 0110 M | | | | | |
| 4. SOCIAL SECURITY NUMBER 219-78-3360 ⁹ | | 5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 34 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) Aug 2, 1960 | | 8. BIRTHPLACE (State or Foreign Country) Md | | | |
| 9a. FACILITY NAME (If not institution, give street and number) 1300 blk. N. Milton Street | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Baltimore | | | | 9c. COUNTY OF DEATH N/A | | | |
| 10a. STATE Md | | 10b. COUNTY N/A | | 10c. CITY, TOWN OR LOCATION Baltimore | | | | 10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | | |
| 10e. STREET AND NUMBER 5 Sugar Loaf Court | | | | 10f. ZIP CODE 21209 | | 10g. CITIZEN OF WHAT COUNTRY? U S A | | | | | |
| 11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: Black | | | | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12th grade College (1-4 or 5+) 4 yrs | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Cashier | | 16b. KIND OF BUSINESS/INDUSTRY Gaint | | | | | |
| 17. FATHER'S NAME (First, Middle, Last) William Carter | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Rosetta Schaired | | | | | | | |
| 19a. INFORMANT'S NAME (Type/Print) William Carter | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5 Sugar Loaf Court Apt 201 Balto, Md 21209 | | | | | | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Md Nat Memorial Park | | DATE 7/20/95 | | 20c. LOCATION — City or Town, State Laurel, Md | | | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Jerome A. Thompson Jr</i> | | | | 22. NAME AND ADDRESS OF FACILITY March F/H West 4300 Wabash Avenue Balto, Md 21215 | | | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <i>Multiple gunshot wounds</i> DUE TO (OR AS A CONSEQUENCE OF): Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. | | | | | | | | Approximate interval Between Onset and Death | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) at scene | | | | | | | | | |
| 27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Could not be determined 4 <input checked="" type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) Found 7/15/95 | | 28b. TIME OF INJURY 0001 M | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED <i>Subject shot</i> | | | |
| 28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) <i>roadway</i> | | | | 28t. LOCATION (Street and Number or Rural Route Number, City or Town, State) <i>1308 North Milton Avenue</i> | | | | | | | |
| 29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER <i>Theodore M. King MD</i> | | | | | | 29c. LICENSE NUMBER O.C.M.E. | | 29d. DATE SIGNED (Month, Day, Year) July 15 1995 | | | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>THEODORE M. KING MD</i> 111 Penn Street, Baltimore, Maryland 21201 | | | | | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JUL 18 1995 <i>John A. ...</i> | | | | | | | | | | | |

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

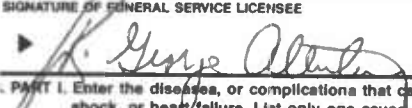

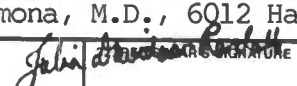
TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

95 21546

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|--|--|---|--|--|---|
| 1. DECEDENT'S NAME (First, Middle, Last) ROBERT LEE COLLINS, JR. | | | | 2. DATE OF DEATH MONTH DAY YEAR July 12, 1995 | | 3. TIME OF DEATH 6:41 A M | |
| 4. SOCIAL SECURITY NUMBER 219-34-3963 | | 5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 56 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) Nov. 19, 1938 | |
| 8. FACILITY NAME (If not institution, give street and number) Good Samaritan Hospital | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Baltimore | | 9c. COUNTY OF DEATH N/A | |
| 10a. STATE Maryland | | | | 10b. COUNTY N/A | | 10c. CITY, TOWN OR LOCATION Baltimore | |
| 10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | | | | |
| 10e. STREET AND NUMBER 3004 White Ave. | | | | 10f. ZIP CODE 21214 | | 10g. CITIZEN OF WHAT COUNTRY? USA | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Civil Engineer | | 16b. KIND OF BUSINESS/INDUSTRY US Army Corps of Eng. | | | |
| 17. FATHER'S NAME (First, Middle, Last) Robert Lee Collins, Sr. | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Valle Ruffner | | | |
| 19a. INFORMANT'S NAME (Type/Print) Cleo D. Collins | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3004 White Ave., Baltimore, MD 21214 | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Parkwood Cemetery | | DATE 7/15 | | 20c. LOCATION — City or Town, State Baltimore, MD | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE  | | | | 22. NAME AND ADDRESS OF FACILITY ALTENBURG FUNERAL HOME, P.A. 6009 Harford Rd., Baltimore, MD 21214 | | | |
| 23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Acute Myocardial Infarction DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. | | | | | | | Approximate interval Between Onset and Death |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DDA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER  Nestor Carmona, M.D. | | | | 29c. LICENSE NUMBER D13649 | | 29d. DATE SIGNED (Month, Day, Year) 7/14/95 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Nestor Carmona, M.D., 6012 Harford Rd., Baltimore, MD 21214 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JUL 18 1995  | | | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 21547

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|---|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) ZELMA FRENCH COLEMAN | | | | 2. DATE OF DEATH MONTH 7 - DAY 11 - YEAR 95 | | 3. TIME OF DEATH 0:00 A M | |
| 4. SOCIAL SECURITY NUMBER 217-16-8395 | | 5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 76 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 5-14-1918 | |
| 9a. FACILITY NAME (If not institution, give street and number) 4320 CLAIRWAY | | | | 9b. CITY, TOWN OR LOCATION OF DEATH BALT CITY | | 9c. COUNTY OF DEATH N/A | |
| 10a. STATE MD | | | | 10b. COUNTY N/A | | 10c. CITY, TOWN OR LOCATION BALT | |
| 10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | | | | | | |
| 10e. STREET AND NUMBER 4320 CLAIRWAY | | | | 10f. ZIP CODE 21213 | | 10g. CITIZEN OF WHAT COUNTRY? USA | |
| 11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: Black | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) (12) College (13-16 or 17+) N/A | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) HOUSEWIFE | | 16b. KIND OF BUSINESS/INDUSTRY Home | | | |
| 17. FATHER'S NAME (First, Middle, Last) HERBERT FRENCH | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) MYRLE BOWIE | | | |
| 19a. INFORMANT'S NAME (Type/Print) LORRAINE TYLER | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 282 S. SPRING CT. BALT MD 21231 | | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) MT ZION CEM. | | DATE 7/17 | | 20c. LOCATION — City or Town, State LANSDOWNE MD. | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i> | | | | 22. NAME AND ADDRESS OF FACILITY BETTS FUNERAL HOME 21213 1129 N. CAROLINE ST BALT MD. | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Myocardial infarct DUE TO (OR AS A CONSEQUENCE OF): b. Coronary artery disease DUE TO (OR AS A CONSEQUENCE OF): c. Chronic renal failure DUE TO (OR AS A CONSEQUENCE OF): d. Approximate Interval Between Onset and Death 0 3 yrs 5 yrs | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. infected dialysis catheter | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| 29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i> | | | | 29c. LICENSE NUMBER D19805 | | 29d. DATE SIGNED (Month, Day, Year) 7/12/95 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Gary Briefer MD 4940 Eastern Ave, Balt. MD 21224 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) 18 1995 | | | | 32. REGISTRAR'S SIGNATURE <i>[Signature]</i> | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) ANGELA Lavern CARTER | | | | 2. DATE OF DEATH MONTH JULY DAY 16, YEAR 1995 | | 3. TIME OF DEATH 02:00 P M | |
| 4. SOCIAL SECURITY NUMBER 213-88-0208 | | 5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 30 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 9-8-64 | |
| 8. BIRTHPLACE (State or Foreign Country) md | | | | 9a. FACILITY NAME (If not institution, give street and number) THE JOHNS HOPKINS HOSPITAL | | 9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE CITY | |
| 9c. COUNTY OF DEATH | | | | 10a. STATE md | | | |
| 10b. COUNTY N/A. | | | | 10c. CITY, TOWN OR LOCATION BALTIMORE | | | |
| 10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | 10e. STREET AND NUMBER 1027 Eveshem Ave | | | |
| 10f. ZIP CODE 21212 | | | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | | | |
| 11. MARITAL STATUS 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: Black | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (1-12) 12th College (1-4 or 5+) 12th | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Laboratory Technician Hospitals | | 16b. KIND OF BUSINESS/INDUSTRY | |
| 17. FATHER'S NAME (First, Middle, Last) BERT CARTER | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Doris Fountain | | | |
| 19a. INFORMANT'S NAME (Type/Print) Doris Fountain | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1027 Eveshem Ave BALTIMORE MD 21212 | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Dulaney Mem Garden 12/13/95 | | 20c. LOCATION — City or Town, State Towson md | | 20d. LOCATION — City or Town, State | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Patricia Butts | | | | 22. NAME AND ADDRESS OF FACILITY BETHS BRUCKER HOME 21213 1129 N. CAROLINE ST. BALTIMORE MD | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. ANEMIA DUE TO (OR AS A CONSEQUENCE OF): b. UPPER GASTROINTESTINAL BLEEDING DUE TO (OR AS A CONSEQUENCE OF): c. RETROVIRAL ILLNESS DUE TO (OR AS A CONSEQUENCE OF): d. Approximate Interval Between Onset and Death 2 DAYS 2 DAYS 4 YEARS | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 28d. DESCRIBE NOW INJURY OCCURRED | | | | 28e. PLACE OF INJURY — At home, term, street, factory, office building, etc. (Specify) | | | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER MATTHEW MOORE MD | | | | 29c. LICENSE NUMBER M2894 | | 29d. DATE SIGNED (Month, Day, Year) July 16, 1995 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) MATTHEW MOORE, JOHNS HOPKINS HOSPITAL, BALTIMORE | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JUL 18 1995 | | | | 32. REGISTRAR'S SIGNATURE John A. Russell | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21201-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|---|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) Patrick Benjamin Cawley | | | | 2. DATE OF DEATH MONTH DAY YEAR July 15 1995 | | 3. TIME OF DEATH 0001 M | |
| 4. SOCIAL SECURITY NUMBER 219-04-3446 | | 5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 19 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) August 21, 75 | |
| 9a. FACILITY NAME (If not institution, give street and number) Johns Hopkins Hospital | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Baltimore | | 9c. COUNTY OF DEATH n/a | |
| 10a. STATE Maryland | | 10b. COUNTY Baltimore | | 10c. CITY, TOWN OR LOCATION Lutherville | | 10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 10e. STREET AND NUMBER 214 Purlington Rd. | | | | 10f. ZIP CODE 21093 | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 2 yrs College (1-4 or 5+) Student | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Student | | 16b. KIND OF BUSINESS/INDUSTRY Education | | | |
| 17. FATHER'S NAME (First, Middle, Last) James Cawley | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Roberta Hall | | | |
| 19a. INFORMANT'S NAME (Type/Print) James F. Cawley | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 214 Purlington Rd. Lutherville, Md. 21093 | | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Dulaney Valley | | DATE 7-19 | | 20c. LOCATION — City or Town, State Timonium, Md. | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | | | | 22. NAME AND ADDRESS OF FACILITY Ruck Towson Funeral Home, Inc. 1050 York Rd. Towson, Md. 21204 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. GUNSHOT WOUND OF CHEST DUE TO (OR AS A CONSEQUENCE OF): b. _____ DUE TO (OR AS A CONSEQUENCE OF): c. _____ DUE TO (OR AS A CONSEQUENCE OF): d. _____ Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | Approximate Interval Between Onset and Death | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 24a. WAS AN AUTOPSY PERFORMED? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) 7/14/95 | | 28b. TIME OF INJURY 2253 PM | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| | | 28d. DESCRIBE HOW INJURY OCCURRED SUBJECT SHOT | | 28e. LOCATION (Street and Number or Rural Route Number, City or Town, State) 5800 CLEARSRING RD, BALTIMORE MD | | | |
| 29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. SIGNATURE AND TITLE OF CERTIFIER | | 29c. LICENSE NUMBER O.C.M.E. | | 29d. DATE SIGNED (Month, Day, Year) July 15 1995 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) MARIO F GOLIS JR MP 111 Penn Street, Baltimore, Maryland 21201 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JUL 18 1995 | | | | 32. REGISTRAR'S SIGNATURE | | | |

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

95 21550

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|---|--|---|--|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last) CATHERINE C. COURTNY | | | | 2. DATE OF DEATH MONTH JULY DAY 14 YEAR 1995 | | 3. TIME OF DEATH 2140 M | |
| 4. SOCIAL SECURITY NUMBER 217-12-8638 | | 5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 8. AGE (In yrs. last birthday) 74 yrs | | 7. DATE OF BIRTH (Month, Day, Year) Jan 15, 1921 | |
| 9a. FACILITY NAME (If not institution, give street and number) Union Memorial Hospital | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Baltimore | | 9c. COUNTY OF DEATH N/A | |
| RESIDENCE OF DECEDENT | | | | | | | |
| 10a. STATE Maryland | | 10b. COUNTY N/A | | 10c. CITY, TOWN OR LOCATION Baltimore | | 10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | |
| 10e. STREET AND NUMBER 3838 Roland Avenue (Apt 1207) | | | | 10f. ZIP CODE 21211 | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12th College (1-4 or 5+) | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Secretary | | 16b. KIND OF BUSINESS/INDUSTRY Gov't State of Maryland | | | |
| 17. FATHER'S NAME (First, Middle, Last) Joseph Collin | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Mary L. Byrne | | | |
| 19a. INFORMANT'S NAME (Type/Print) Robert Collin | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1805 Parkvue Rd, Fallston, Md 21047 | | | |
| 20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Green Mount Cem | | DATE 7/17 | | 20c. LOCATION — City or Town, State Baltimore, Md | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE A. Alan Seitz, Jr. | | | | 22. NAME AND ADDRESS OF FACILITY A. Alan Seitz, Jr. Funeral Home 3818 Roland Ave., Baltimore, Md 21211 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. CHF (congestive heart failure) 2° to dilated cardiomyopathy b. As above c. d. Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events that initiated events resulting in death) LAST | | | | | | | Approximate interval Between Onset and Death |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Hypothyroidism, Hypernatremia | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | | | | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28e. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER Seema (Suraia Begum), MD. | | | | 29c. LICENSE NUMBER AT2438946 | | 29d. DATE SIGNED (Month, Day, Year) 7/14/95 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) SURAIYA BEGUM, Medicine, The Union Memorial Hospital, Baltimore, MD-21218 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JUL 18 1995 | | | | 32. REGISTRAR'S SIGNATURE J. A. [Signature] | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 21551

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|---|--|--|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) MINA COLSON | | | | 2. DATE OF DEATH MONTH JULY DAY 13 YEAR 1995 | | 3. TIME OF DEATH 8:40 am M | |
| 4. SOCIAL SECURITY NUMBER 216-48-4382 | | 5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 95 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) FEB. 22, 1900 | |
| 9a. FACILITY NAME (If not institution, give street and number) MILFORD MANOR NURSING HOME | | | | 9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE | | 9c. COUNTY OF DEATH BALTIMORE | |
| RESIDENCE OF DECEDENT | | | | | | | |
| 10a. STATE MARYLAND | | 10b. COUNTY N/A | | 10c. CITY, TOWN OR LOCATION BALTIMORE | | 10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 10e. STREET AND NUMBER 3201 LABYRINTH ROAD | | | | 10f. ZIP CODE 21208 | | 10g. CITIZEN OF WHAT COUNTRY? USA | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: WHITE | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) HOUSEWIFE | | 16b. KIND OF BUSINESS/INDUSTRY OWN HOME | | | |
| 17. FATHER'S NAME (First, Middle, Last) MICHAEL MICHOLSKY | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) SARAH UNKNOWN | | | |
| 19a. INFORMANT'S NAME (Type/Print) MRS. DORIS GRESSER | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2713 SUMMERSON ROAD BALTIMORE, MD 21209 | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) ARLINGTON-CHIZUK AMUNO | | 20c. LOCATION — City or Town, State 7-16-1995 BALTIMORE, MD | | 20d. DATE | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i> | | | | 22. NAME AND ADDRESS OF FACILITY SOL LEVINSON & BROS., INC. 6010 REISTERSTOWN ROAD BALTIMORE, MD 21215 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. cardiac arrest DUE TO (OR AS A CONSEQUENCE OF): b. arteriosclerotic vascular disease DUE TO (OR AS A CONSEQUENCE OF): c. diabetes DUE TO (OR AS A CONSEQUENCE OF): d. Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DDA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 6 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide | | | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | |
| 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i> | | | | 29c. LICENSE NUMBER D42956 | | 29d. DATE SIGNED (Month, Day, Year) 7/13/95 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Linda Preysner 21 Crossroads Drive Suite 21 Owings Mills MD 21117 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JUL 18 1995 | | | | 32. REGISTRAR'S SIGNATURE <i>[Signature]</i> | | | |

DHMH-18 Rev 1/89

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

6

95 21552

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|---|--|---|--|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last) Audrey Chalk | | | | 2. DATE OF DEATH MONTH July DAY 13 YEAR 1995 | | 3. TIME OF DEATH 7:15pm M | |
| 4. SOCIAL SECURITY NUMBER 085-26-0131 | | 5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 63 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) March 1, 1932 | |
| 9a. FACILITY NAME (If not institution, give street and number) 730 Corby Road | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Essex | | 9c. COUNTY OF DEATH Baltimore | |
| RESIDENCE OF DECEDENT | | | | | | | |
| 10a. STATE Md. | | 10b. COUNTY Baltimore | | 10c. CITY, TOWN OR LOCATION Essex | | 10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 10e. STREET AND NUMBER 730 Corby Road | | | | 10f. ZIP CODE 21221 | | 10g. CITIZEN OF WHAT COUNTRY? USA | |
| 11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12th | | 15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Secretary | | 16b. KIND OF BUSINESS/INDUSTRY Dreging Co. | | | |
| 17. FATHER'S NAME (First, Middle, Last) Henry Kupka | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Edna Poole | | | |
| 19a. INFORMANT'S NAME (Type/Print) Ernest Chalk | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 730 Corby Road Baltimore Md. 21221 | | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Holly Hill Cemetery | | 20c. LOCATION — City or Town, State Baltimore Md. | | 20d. DATE 7/17/95 | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE R. Terry Connelly | | | | 22. NAME AND ADDRESS OF FACILITY Connelly Funeral Home of Essex 300 Mace Ave. Baltimore Md. 21221 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Cardio respiratory Arrest CHRONIC CANCER Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST | | | | | | | Approximate Interval Between Onset and Death |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO | | | | | | | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) 7/17/95 | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28e. DESCRIBE HOW INJURY OCCURRED | | | |
| 29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. SIGNATURE AND TITLE OF CERTIFIER NEIL ROSENSTEIN, M.D. | | 29c. LICENSE NUMBER 100372 | | 29d. DATE SIGNED (Month, Day, Year) 7/17/95 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) NEIL ROSENSTEIN, M.D. 550 N. BROADWAY BALTO. MD 21205 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JUL 18 1995 | | 32. REGISTRAR'S SIGNATURE John Andrew Roshell | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 21553

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) Elsie May Chapin | | | | 2. DATE OF DEATH MONTH DAY YEAR July 13, 1995 | | 3. TIME OF DEATH 11:00pm M | |
| 4. SOCIAL SECURITY NUMBER 212-09-1069 | | 5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 75 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) March 17, 1920 | |
| 9a. FACILITY NAME (If not institution, give street and number) 12938 Community Drive | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Harewood Park | | 9c. COUNTY OF DEATH Baltimore | |
| 10a. STATE Md. | | 10b. COUNTY Baltimore | | 10c. CITY, TOWN OR LOCATION Essex | | 10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| 10a. STREET AND NUMBER 137 Wiltshire Road | | | | 10f. ZIP CODE 21221 | | 10g. CITIZEN OF WHAT COUNTRY? USA | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 7th College (1-4 or 5+) | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Housewife | | 16b. KIND OF BUSINESS/INDUSTRY own home | | | |
| 17. FATHER'S NAME (First, Middle, Last) William Shine | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Margaret Behr | | | |
| 19a. INFORMANT'S NAME (Type/Print) Dennis Yurek | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8012 Yellowstone Road Kingsville MD. 21087 | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 6 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) BelAir Memorial 7/17/95 | | 20c. LOCATION — City or Town, State BelAir Md. | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE L. Terry Connelly | | | | 22. NAME AND ADDRESS OF FACILITY Connelly Funeral Home of Essex 300 Mace Ave. Baltimore Md. 21221 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Acute myocardial infarction | | | | | | Approximate Interval Between Onset and Death | |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | | | | | | | |
| Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/> | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| 29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER J. Crossan Johnson, M.D. | | | | 29c. LICENSE NUMBER 207632 | | 29d. DATE SIGNED (Month, Day, Year) 7-14-95 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) J. Crossan Johnson 2112 DUNDALK AVE BALTO MD 21222 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JUL 18 1995 | | | | 32. REGISTRAR'S SIGNATURE John Andrew Randall | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR
STATE
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) <i>Colbert, Anna</i> | | | | 2. DATE OF DEATH MONTH <i>July</i> DAY <i>15</i> YEAR <i>95</i> | | 3. TIME OF DEATH <i>5:05 P M</i> | |
| 4. SOCIAL SECURITY NUMBER <i>214-24-5618</i> | | 5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) <i>65</i> YRS. | | 7. DATE OF BIRTH (Month, Day, Year) <i>4-27-30</i> | |
| 8. FACILITY NAME (If not institution, give street and number) <i>St. Agnes Hospital</i> | | | | 9. CITY, TOWN OR LOCATION OF DEATH <i>BALTO.</i> | | 10. COUNTY OF DEATH <i>N/A.</i> | |
| 11. RESIDENCE OF DECEDENT | | | | 12. STATE <i>md.</i> | | 13. COUNTY <i>N/A.</i> | |
| 14. STREET AND NUMBER <i>801 Wintars Lane</i> | | | | 15. ZIP CODE <i>21228</i> | | 16. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i> | |
| 17. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced | | 18. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 19. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 20. RACE — American Indian, Black, White, etc. Specify: <i>BLACK</i> | |
| 21. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <i>12</i> College (1-4 or 5+) <i>5</i> | | 22. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <i>Dietitian</i> | | 23. KIND OF BUSINESS/INDUSTRY <i>Hosp.</i> | | | |
| 24. FATHER'S NAME (First, Middle, Last) <i>Claudio R. Hubbard</i> | | | | 25. MOTHER'S NAME (First, Middle, Maiden Surname) <i>MARY T. Williams</i> | | | |
| 26. INFORMANT'S NAME (Type/Print) <i>Deborah Holland</i> | | | | 27. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>3701 TRENT RD RADALLSTOWN MD 21133</i> | | | |
| 28. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 29. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <i>Gooden PARK Cem 12/18/95</i> | | 30. LOCATION — City or Town, State <i>BALTO. MD.</i> | | 31. DATE OF DISPOSITION <i>12/18/95</i> | |
| 32. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Cathleen Bitts</i> | | | | 33. NAME AND ADDRESS OF FACILITY <i>BETTS FUNERAL HOME 21213 1129 N. CAROLINE ST BALT. MD</i> | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>CVA</i> DUE TO (OR AS A CONSEQUENCE OF): a. <i>CVA</i> b. <i>metabolic disorders</i> c. <i>Anemia</i> d. <i>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST</i> PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Renal Failure</i> | | | | | | | |
| 24. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 25. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | |
| 26. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 27. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 28. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined | | 29. DATE OF INJURY (Month, Day, Year) | | 30. TIME OF INJURY <i>M</i> | | 31. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| 32. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 33. DESCRIBE HOW INJURY OCCURRED | | | |
| 34. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | 35. DATE SIGNED (Month, Day, Year) <i>8/15/95</i> | | | |
| 29. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 30. SIGNATURE AND TITLE OF CERTIFIER <i>James J. Randall</i> | | | | 31. LICENSE NUMBER <i>20276</i> | | 32. DATE SIGNED (Month, Day, Year) <i>8/15/95</i> | |
| 33. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>James J. Randall 900 CATON AVE 21229</i> | | | | | | | |
| 34. DATE FILED (Month, Day, Year) <i>JUL 18 1995</i> | | 35. REGISTRAR'S SIGNATURE <i>James J. Randall</i> | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 21555

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|---|--|--|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) Bennett, Chalk | | | | 2. DATE OF DEATH MONTH DAY YEAR July 12 1995 | | 3. TIME OF DEATH 0245 AM | |
| 4. SOCIAL SECURITY NUMBER 220-01-2183 | | 5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 76 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 3-18-19 | |
| 9a. FACILITY NAME (If not institution, give street and number) Northwest Hospital Center | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Randallstown | | 9c. COUNTY OF DEATH Baltimore | |
| 10a. STATE Maryland | | | | 10b. COUNTY Baltimore | | 10c. CITY, TOWN OR LOCATION Reisterstown | |
| 10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input type="checkbox"/> NO | | | | 10e. STREET AND NUMBER 12020 Reisterstown Road | | | |
| 10f. ZIP CODE 21136 | | | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | | | |
| 11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 8th grade College (1-4 or 5+) College | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Foreman | | 16b. KIND OF BUSINESS/INDUSTRY Bureau of Recreation and Parks | | | |
| 17. FATHER'S NAME (First, Middle, Last) William Raymond Chalk | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Annie Marie Chalk-Werntzman | | | |
| 19a. INFORMANT'S NAME (Type/Print) Dorothy Yingling | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 407 Hammershire Road-Owings Mills, MD. 21117 | | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) | | DATE | | 20c. LOCATION — City or Town, State | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Ronald Wade, Dir. | | | | 22. NAME AND ADDRESS OF FACILITY State Anatomy Board 655 W. Baltimore St., Baltimore, MD. 21201 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | | | | | | | |
| a. Respiratory Arrest DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| b. Anemia DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| c. Prostate Cancer with metastatic lesions DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| d. | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | | | | |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | | | | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28d. DESCRIBE NOW INJURY OCCURRED | | | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | 29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER Shirley Schaefer, M.D. | | | | 29c. LICENSE NUMBER D31296 | | 29d. DATE SIGNED (Month, Day, Year) July 12, 1995 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JUL 17 1995 | | | | 32. REGISTRAR'S SIGNATURE John R. Ball | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 21556

ITEMS: 1.9c, 10b, PER F.H. FILM G-725 7/18/95 t.t

FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|---|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) <u>DORSEY BESSIE MAE DORSEY</u> | | | | 2. DATE OF DEATH MONTH <u>July</u> DAY <u>15</u> YEAR <u>95</u> | | 3. TIME OF DEATH <u>3:18A.M.</u> | |
| 4. SOCIAL SECURITY NUMBER <u>220-64-7850</u> | | 5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) <u>38</u> YRS. | | 7. DATE OF BIRTH (Month, Day, Year) <u>NOV. 3, 1956</u> | |
| 8a. FACILITY NAME (If not institution, give street and number) <u>UNION MEMORIAL HOSPITAL</u> | | | | 8b. CITY, TOWN OR LOCATION OF DEATH <u>Baltimore</u> | | 8c. COUNTY OF DEATH <u>U.S.A. N/A</u> | |
| RESIDENCE OF DECEDENT | | | | | | | |
| 10a. STATE <u>MARYLAND</u> | | 10b. COUNTY <u>U.S.A. N/A</u> | | 10c. CITY, TOWN OR LOCATION <u>Baltimore</u> | | 10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 10e. STREET AND NUMBER <u>1708 N. BRADFORD STREET</u> | | | | 10f. ZIP CODE <u>21213</u> | | 10g. CITIZEN OF WHAT COUNTRY? <u>UNITED STATES</u> | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: <u>BLACK</u> | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <u>12 TH</u> College (1-4 or 5+) <u>-</u> | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <u>CARE WORKER</u> | | 16b. KIND OF BUSINESS/INDUSTRY <u>ROSEWOOD CENTER</u> | | | |
| 17. FATHER'S NAME (First, Middle, Last) <u>MELVIN JACKSON</u> | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) <u>JANIE MC CULLOUGH</u> | | | |
| 19a. INFORMANT'S NAME (Type/Print) <u>CAROLE JACKSON</u> | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>2861 LAKE AVENUE, BALTIMORE, MD 21213</u> | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <u>GARRISON FOREST VA CEM. 7-21</u> | | 20c. LOCATION — City or Town, State <u>OWINGS MILLS, MD</u> | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <u>[Signature]</u> | | | | 22. NAME AND ADDRESS OF FACILITY <u>WM. C. MARCH FH.-1101 E. NORTH AVENUE</u> | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | | a. <u>cardiovascular arrest</u> | | | | Approximate interval between Onset and Death <u>3 hours</u> | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | b. <u>terminal AIDS</u> | | | | <u>1 Year</u> | |
| | | c. DUE TO (OR AS A CONSEQUENCE OF): | | | | | |
| | | d. DUE TO (OR AS A CONSEQUENCE OF): | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/> | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY <u>M</u> | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER <u>Beena Nappal</u> | | | | 29c. LICENSE NUMBER <u>AT2438946</u> | | 29d. DATE, SIGNED (Month, Day, Year) <u>JULY 15/95</u> | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <u>BEENA NAPPAL - Union Memorial Hosp.</u> | | | | | | | |
| 31. DATE FILED (Month, Day, Year) <u>JUL 18 1995</u> | | | | 32. REGISTRAR'S SIGNATURE <u>[Signature]</u> | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

P.O. BOX 68760

10

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 21557

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|--|--|---|--|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last) BEATRICE FAIRALL DOWNS | | | | 2. DATE OF DEATH MONTH JULY DAY 12 YEAR 1995 | | 3. TIME OF DEATH 12:35 P. M. | |
| 4. SOCIAL SECURITY NUMBER 215-09-5703 | | 5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 78 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 10-08-1916 | |
| 8a. FACILITY NAME (If not institution, give street and number) NORTH ARUNDEL CONVALESCENT CENTER | | | | 8b. CITY, TOWN OR LOCATION OF DEATH GLEN BURNIE | | 8c. COUNTY OF DEATH ANNE ARUNDEL | |
| 9a. STATE MARYLAND | | | | 9b. COUNTY ANNE ARUNDEL | | 9c. CITY, TOWN OR LOCATION GLEN BURNIE | |
| 10a. STREET AND NUMBER 305 NEWFIELD ROAD | | | | 10b. ZIP CODE 21061 | | 10c. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: WHITE | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (8-12) 12 College (1-4 or 5+) N/A | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) SECRETARY | | 16b. KIND OF BUSINESS/INDUSTRY WRIGHT CONSTRUCTION | |
| 17. FATHER'S NAME (First, Middle, Last) WALTER RAY FAIRALL | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) MATTIE BROTHERTON | | | |
| 19a. INFORMANT'S NAME (Type/Print) CARLOS A. DOWNS | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8453 LIBERTY PARKWAY, BALTIMORE, MD. 21222 | | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) NICHOLS BETHEL CEMETERY | | 20c. LOCATION — City or Town, State 7/15/95 ODENTON, MD. | | 20d. DATE | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i> | | | | 22. NAME AND ADDRESS OF FACILITY SINGLETON FUNERAL HOME, 1 SECOND AVENUE, S.W. GLEN BURNIE, MARYLAND 21061 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Coronary artery Disease DUE TO (OR AS A CONSEQUENCE OF): Hypertension DUE TO (OR AS A CONSEQUENCE OF): CVA DUE TO (OR AS A CONSEQUENCE OF): Hypothyroidism Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST | | | | | | | Approximate Interval Between Onset and Death |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Arteriosclerosis | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | | | | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | 28g. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i> | | | | 29c. LICENSE NUMBER D22206 | | 29d. DATE SIGNED (Month, Day, Year) 7 13 95 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) MUSTAFA C. OZ M.D., PROADNECK MEDICAL CENTER, STE. 273 B ARNOLD, MD. 21012 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JUL 18 1995 | | | | 32. REGISTRAR'S SIGNATURE <i>[Signature]</i> | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.


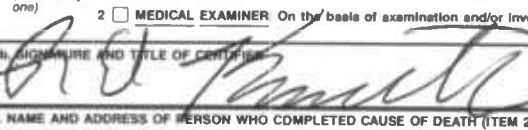
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

REG. NO.

DHMH-16 Rev 1/89

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|--|--|--|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) DAN Lewis DIXON, JR | | | | 2. DATE OF DEATH MONTH JULY DAY 11 YEAR 1995 | | 3. TIME OF DEATH 0608 | |
| 4. SOCIAL SECURITY NUMBER 036-24-6637 | | 5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 68 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) Aug 17 1928 Fla | |
| 9a. FACILITY NAME (If not institution, give street and number) Kimbrough Hospital | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Ft Meade | | 9c. COUNTY OF DEATH Anne Arundel | |
| RESIDENCE OF DECEDENT | | | | | | | |
| 10a. STATE Md | | 10b. COUNTY Anne Arundel | | 10c. CITY, TOWN OR LOCATION Gambrills | | 10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 10e. STREET AND NUMBER 1139 Md Rte 3, N. Lane | | | | 10f. ZIP CODE 21054 | | 10g. CITIZEN OF WHAT COUNTRY? USA | |
| 11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES WW II | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: Black | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) 12th | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Salesman | | 16b. KIND OF BUSINESS/INDUSTRY Auto Industry | | | |
| 17. FATHER'S NAME (First, Middle, Last) Dan L. Dixon Sr. | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Beatrice (unk) Smith | | | |
| 19a. INFORMANT'S NAME (Type/Print) McManus Maudeen McManus Dixon | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1139 Md Rte 3, N. Lane, Gambrills, Md 21054 | | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Arlington Natl. Cem. | | DATE 7-19 | | 20c. LOCATION — City or Town, State Arlington, Va | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE  | | | | 22. NAME AND ADDRESS OF FACILITY Hardesty Funeral Home P.A., 851 Annapolis Rd., Gambrills, Md 21054 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → PULMONARY EMBOLUS DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST GASTROINTESTINAL ILEUS DUE TO (OR AS A CONSEQUENCE OF): LOCALIZED PROSTATE CANCER DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | 24a. WAS AN AUTOPSY PERFORMED? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | |
| 27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28d. DESCRIBE HOW INJURY OCCURRED | | | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | 29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER  | | | | 29c. LICENSE NUMBER AL 13830 | | 29d. DATE SIGNED (Month, Day, Year) JULY 12, 1995 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) RICHARD A. KURNET, M.D. KIMBROUGH ARMY COMMUNITY HOSP, FT. MEADE, MD 20755 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JUL 18 1995 | | | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.


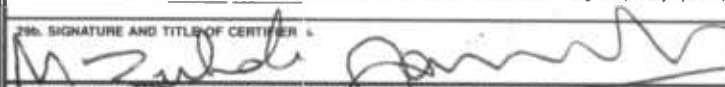


TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 21560

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|---|--|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last) PETER JAMES DOERR | | | | 2. DATE OF DEATH MONTH DAY YEAR JUL 10 1995 | | 3. TIME OF DEATH 1:21 P M | |
| 4. SOCIAL SECURITY NUMBER 058-24-4663 | | 5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 62 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) May 2 1933 | |
| 9a. FACILITY NAME (If not institution, give street and number) NATIONAL NAVAL MEDICAL CENTER | | | | 9b. CITY, TOWN OR LOCATION OF DEATH BETHESDA | | 9c. COUNTY OF DEATH MONTGOMERY | |
| 10a. STATE Virginia | | | | 10b. COUNTY | | 10c. CITY, TOWN OR LOCATION Alexandria | |
| 10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | | | 10e. STREET AND NUMBER 905 W Braddock Rd. | | | |
| 10f. ZIP CODE 22302 | | | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | | | |
| 11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES WWII | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: WHITE | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 5+ | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) OFFICER | | 16b. KIND OF BUSINESS/INDUSTRY U.S. Navy | | | |
| 17. FATHER'S NAME (First, Middle, Last) Walter Doerr | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Agnes James | | | |
| 19a. INFORMANT'S NAME (Type/Print) Mary A Doerr | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 905 W Braddock Rd. Alex. VA 22302 | | | |
| 20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input checked="" type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) BURIAL @ SEA | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) BURIAL @ SEA | | 20c. DATE JULY 1995 | | 20d. LOCATION — City or Town, State MASS. | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE  | | | | 22. NAME AND ADDRESS OF FACILITY Everly-Wheatley Funeral Home 1500 W Braddock Rd. Alex. VA | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. RUPTURED AORTIC ANEURYSM DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | | Approximate Interval Between Onset and Death |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | | | | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/> | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> 4 Nursing Home <input type="checkbox"/> 5 Residence <input type="checkbox"/> 6 Other (Specify) | | | | | |
| 27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER  | | | | 29c. LICENSE NUMBER 0101050362 (VA) | | 29d. DATE SIGNED (Month, Day, Year) 11 July 95 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) M. ZUBERI JASSER, LT, MC, USNR | | | | 31. DATE FILED (Month, Day, Year) JUL 18 1995 | | | |
| 32. REGISTRAR'S SIGNATURE  | | | | 33. REGISTRAR'S SIGNATURE  | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

24

95 21561

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|---|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) LOUIS ELLER | | | | 2. DATE OF DEATH MONTH JULY DAY 15 YEAR 1995 | | 3. TIME OF DEATH 8:55 A M | |
| 4. SOCIAL SECURITY NUMBER 577-05-4547 | | 5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 79 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) APR. 11, 1916 | |
| 8. FACILITY NAME (If not institution, give street and number) JEWISH CONVALESCENT HOME | | | | 9. CITY, TOWN OR LOCATION OF DEATH BALTIMORE | | 10. COUNTY OF DEATH BALTIMORE | |
| 11. STATE MD | | 12. COUNTY BALTIMORE | | 13. CITY, TOWN OR LOCATION BALTIMORE | | 14. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| 15. STREET AND NUMBER 7920 SCOTTS LEVEL RD. | | | | 16. ZIP CODE 21208 | | 17. CITIZEN OF WHAT COUNTRY? USA | |
| 18. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 19. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES WWII-ARMY AIR CORP | | 20. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 21. RACE — American Indian, Black, White, etc. Specify: WHITE | |
| 22. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (1-4 or 5+) WIREMAN | | 23. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) WIREMAN | | 24. KIND OF BUSINESS/INDUSTRY ELECTRONICS | | | |
| 25. FATHER'S NAME (First, Middle, Last) HYMAN ELLER | | | | 26. MOTHER'S NAME (First, Middle, Maiden Surname) ROSE SACHS | | | |
| 27. INFORMANT'S NAME (Type/Print) STEVE ELLER | | | | 28. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3113 HATTON ROAD, BALTO, MD 21208 | | | |
| 29. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 30. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) BNAT ISRAEL | | 31. DATE 7-16-95 | | 32. LOCATION — City or Town, State BALTIMORE, MD | |
| 33. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i> | | | | 34. NAME AND ADDRESS OF FACILITY SOL LEVINSON & BROS., INC. 6010 REISTERSTOWN ROAD BALTIMORE MD 21215 | | | |
| 35. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Congestive Heart Failure DUE TO (OR AS A CONSEQUENCE OF): b. Coronary Artery Disease Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST c. _____ DUE TO (OR AS A CONSEQUENCE OF): d. _____ | | | | | | | |
| 36. PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/> | | | | | | | |
| 37. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 38. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DDA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 39. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 6 <input type="checkbox"/> Could not be determined | | 40. DATE OF INJURY (Month, Day, Year) | | 41. TIME OF INJURY M | | 42. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 43. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 44. DESCRIBE HOW INJURY OCCURRED | | | |
| 45. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 46. SIGNATURE AND TITLE OF CERTIFIER Erik L. Russell, MD | | | | | |
| 47. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Erik L. Russell, M.D., 8620 Liberty Plaza Mall, Randallstown, MD 21133 | | 48. LICENSE NUMBER D43623 | | 49. DATE SIGNED (Month, Day, Year) 7/17/95 | | | |
| 50. DATE FILED (Month, Day, Year) JUL 18 1995 | | 51. REGISTRAR'S SIGNATURE <i>[Signature]</i> | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95-4157-510

CIP

ITEMS: 23 PART I, 27, 28a-f, PER MEO FILM G-7248/1/95 t.t

95 21562

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|--|--|---|--|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last) Samuel Lewis Fowlkes | | | | 2. DATE OF DEATH MONTH July DAY 16, YEAR 1995 | | 3. TIME OF DEATH 15:47 P M | |
| 4. SOCIAL SECURITY NUMBER 212-60-2903 | | 5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 42 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 10-20-52 | |
| 8. BIRTHPLACE (State or Foreign Country) Maryland | | 9a. FACILITY NAME (If not institution, give street and number) 741 Patterson Park Ave. | | 9b. CITY, TOWN OR LOCATION OF DEATH Baltimore | | 9c. COUNTY OF DEATH None | |
| 10a. STATE Maryland | | 10b. COUNTY None | | 10c. CITY, TOWN OR LOCATION Baltimore | | 10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | |
| 10e. STREET AND NUMBER 741 Patterson Park Ave. | | | | 10f. ZIP CODE 21205 | | 10g. CITIZEN OF WHAT COUNTRY? USA | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: Black | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 12 | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Construction | | 16b. KIND OF BUSINESS/INDUSTRY Unknown | | | |
| 17. FATHER'S NAME (First, Middle, Last) Bobby Branch | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Alice Fowlkes | | | |
| 19a. INFORMANT'S NAME (Type/Print) Charlene Fowlkes | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1734 Thomas Ave. Balto., Md. 21216 | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Maryland National | | DATE 7/21 | | 20c. LOCATION — City or Town, State Laurel, Md. | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | | | | 22. NAME AND ADDRESS OF FACILITY Derrick C. Jones Funeral Home 4611 Park Heights Ave. | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. NARCOTIC INTOXICATION DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. | | | | | | | Approximate interval Between Onset and Death |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | | | | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 6 <input checked="" type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) FOUND ON 7/16/95 | | 28b. TIME OF INJURY 3:47 P M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED UNKNOWN | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) FOUND AT HOME | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) 741 PATTERSON PARK AVE. BALTIMORE, MD. | | | |
| 29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER | | | | 29c. LICENSE NUMBER O.C.M.E. | | 29d. DATE SIGNED (Month, Day, Year) JULY 17, 1995 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) DAVID R. FOWLER M.D. 111 Penn Street, Baltimore, Maryland 21201 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JUL 18 1995 | | 32. REGISTRAR'S SIGNATURE | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

BALTIMORE, MARYLAND 21215-0020

BALTIMORE, MARYLAND 21215-0020

BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) ANDREW J. FAVA | | | | 2. DATE OF DEATH MONTH DAY YEAR July 17, 1995 | | 3. TIME OF DEATH 1 P. | |
| 4. SOCIAL SECURITY NUMBER 214-03-1982 | | 5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 88 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) Sept 13, 1907 | |
| 9a. FACILITY NAME (If not institution, give street and number) 1819 Leadburn Avenue | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Towson | | 9c. COUNTY OF DEATH Baltimore | |
| RESIDENCE OF DECEDENT | | | | | | | |
| 10a. STATE Md | | 10b. COUNTY Baltimore | | 10c. CITY, TOWN OR LOCATION N/A | | 10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input type="checkbox"/> NO | |
| 10e. STREET AND NUMBER 7001 Bristol Road | | | | 10f. ZIP CODE 21212 | | 10g. CITIZEN OF WHAT COUNTRY? USA | |
| 11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: white | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 10 College (1-4 or 5+) 10 | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) President | | 16b. KIND OF BUSINESS/INDUSTRY Produce Company | | | |
| 17. FATHER'S NAME (First, Middle, Last) Frank A. Fava | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Castenzia D'Antoni | | | |
| 19a. INFORMANT'S NAME (Type/Print) Constance Potthast | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1819 Leadburn Avenue, Towson, Md. 21204 | | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Dulaney Valley Maus. 7/20 | | 20c. LOCATION — City or Town, State Timonium, Md | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Peter S. Galt | | | | 22. NAME AND ADDRESS OF FACILITY Sterling Ashton Funeral Home 736 Edmondson Avenue, Balto. Md. 21228 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → Liver Metastasis | | | | | | | |
| DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| Sequitely ill conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST | | | | | | | |
| DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Diabetes Mellitus | | | | | | | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| 29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER Arthur A. Serpick MD | | | | 29c. LICENSE NUMBER D 10091 | | 29d. DATE SIGNED (Month, Day, Year) 7/18/95 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Arthur A. Serpick MD St Joseph Medical Center | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JUL 18 1995 | | | | 32. REGISTRAR'S SIGNATURE John Anderson Randall | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) DONNA FARRELL | | | | 2. DATE OF DEATH MONTH JULY DAY 10 YEAR 1995 | | 3. TIME OF DEATH 5:15 A | |
| 4. SOCIAL SECURITY NUMBER 214-86-3549 | | 5. SEX 1 <input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 33 32 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) MAY 3, 1962 | |
| 8. BIRTHPLACE (State or Foreign Country) MARYLAND | | | | 9a. FACILITY NAME (If not institution, give street and number) LEVINDALE N. H. | | 9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE | |
| 9c. COUNTY OF DEATH N/A | | | | 10a. STATE MD. | | 10b. COUNTY BALTIMORE | |
| 10c. CITY, TOWN OR LOCATION N/A | | | | 10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 10e. STREET AND NUMBER 6916 BROOKMILL RD. | |
| 10f. ZIP CODE 21215 | | | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | | 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced | |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR OATHS | | | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: WHITE | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) N/A College (1-4 or 5+) N/A | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) HOMEMAKER | | 16b. KIND OF BUSINESS/INDUSTRY OWN HOME | |
| 17. FATHER'S NAME (First, Middle, Last) JOHN P. SCOTT | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) NANCY L. MOORE | | | |
| 19a. INFORMANT'S NAME (Type/Print) ARTHUR DRAGER (Attorney) | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5 LIGHT ST. SUITE 510 BALTO. MD. 21202 | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematorium, or other place) VOSSHELLS CEH 7-13-95 BALTO. MD. | | 20c. LOCATION — City or Town, State | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Thomas J. Skarda Jr.</i> | | | | 22. NAME AND ADDRESS OF FACILITY SKARDA F.H. 2829 HUDSON ST. BALTO. MD. 21224 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Sepsis DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Approximate Interval Between Onset and Death ≈ 2 day | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. recurrent emboli pulmonary emboli DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER <i>Mesam - physician</i> | | | | 29c. LICENSE NUMBER 344817 | | 29d. DATE SIGNED (Month, Day, Year) July 10, 1995 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) SYNTH. P. PASTOR I 2434 West Behadere Ave Baltimore. | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JUL 18 1995 | | | | 32. REGISTRAR'S SIGNATURE <i>Ch. D. ...</i> | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 21565

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|--|--|---|--|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last) GEORGE F FINKE | | | | 2. DATE OF DEATH MONTH JULY DAY 15 YEAR 1995 | | 3. TIME OF DEATH 10:28 P M | |
| 4. SOCIAL SECURITY NUMBER 212-01-7240 | | 5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 79 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 10-26-15 | |
| 9a. FACILITY NAME (If not institution, give street and number) GREATER BALTIMORE MEDICAL CENTER | | | | 9b. CITY, TOWN OR LOCATION OF DEATH TOWSON | | 9c. COUNTY OF DEATH BALTIMORE | |
| 10a. STATE Maryland | | | | 10b. COUNTY n/a | | 10c. CITY, TOWN OR LOCATION Baltimore | |
| 10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | | | 10e. STREET AND NUMBER 1435 Meridene Dr. | | | |
| 10f. ZIP CODE 21239 | | | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | | | |
| 11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES WW II | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 4 yrs | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Engineer | | 16b. KIND OF BUSINESS/INDUSTRY Engineering | | | |
| 17. FATHER'S NAME (First, Middle, Last) Egbert A. Finke | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Lillian Beck | | | |
| 19a. INFORMANT'S NAME (Type/Print) Julia A. Finke | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1435 Meridene Dr. Baltimore, Md. 21239 | | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Holy Redeemer | | 20c. LOCATION — City or Town, State 7-20 Baltimore, Md. | | 20d. DATE | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | | | | 22. NAME AND ADDRESS OF FACILITY Ruck Towson Funeral Home, Inc. 1050 York Rd. Towson, Md. 21204 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. multiorgan dysfunction 2° Staph Sepsis DUE TO (OR AS A CONSEQUENCE OF): b. Diabetes mellitus. DUE TO (OR AS A CONSEQUENCE OF): c. E DUE TO (OR AS A CONSEQUENCE OF): d. | | | | | | | Approximate interval Between Onset and Death Days. Yrs |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Hypoglycemia, End stage renal disease Cardiomyopathy & ASCVD | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | | | | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 28d. DESCRIBE NOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER Joel S. Lahn | | | | 29c. LICENSE NUMBER D39116 | | 29d. DATE SIGNED (Month, Day, Year) 7/16/95 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) JOEL S. LAHN 1818 Pot Spring Rd Suite 102 Lutherville MD 21093 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JUL 18 1995 | | | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

P.O. BOX 68760

15

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 21566

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | |
|---|--|--|--|---|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) PAUL WILLIAM FRIEL SR. | | | | 2. DATE OF DEATH MONTH July DAY 16 YEAR 95 | | | | 3. TIME OF DEATH 6¹⁰ A M | |
| 4. SOCIAL SECURITY NUMBER 219-07-1743 | | 5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F | 6. AGE (in yrs. last birthday) 74 YRS. | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS. HOURS MIN. | | 7. DATE OF BIRTH (Month, Day, Year) February 10, 1921 | |
| 8. BIRTHPLACE (State or Foreign Country) Maryland | | | | 9a. FACILITY NAME (If not institution, give street and number) Stella Maris Hospive | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Towson | |
| 9c. COUNTY OF DEATH Baltimore | | | | 10a. STATE Maryland | | | | 10b. COUNTY N/A | |
| 10c. CITY, TOWN OR LOCATION Baltimore, City | | | | 10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | | | 10e. STREET AND NUMBER 4608 Mannasota Ave. | |
| 10f. ZIP CODE 21206 | | | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | | | | 11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES WWII | | | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | | | 14. RACE — American Indian, Black, White, etc. Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 10 College (1-4 or 5+) College | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Mechanic Foreman | | | | 16b. KIND OF BUSINESS/INDUSTRY State Hiway Admin. | |
| 17. FATHER'S NAME (First, Middle, Last) John P. Friel | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Margaret Dunn | | | | 19a. INFORMANT'S NAME (Type/Print) Mrs. Agnes Friel | |
| 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) Same as 10e | | | | 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Gardens of Faith 7/19/95 | |
| 20c. LOCATION — City or Town, State Baltimore, Maryland | | | | 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Ronald E. Faulkner</i> | | | | 22. NAME AND ADDRESS OF FACILITY Leonard J. Ruck Funeral Home, Inc. 5305 Harford Road Balto. Md. 21214 | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. LUNG CANCER, NON-SMALL CELL DUE TO (OR AS A CONSEQUENCE OF): Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. | | | | | | | | Approximate Interval Between Onset and Death 2 mos. | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO | | | | | | | | DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/> | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) HOSPICE | | | | | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED | |
| 28e. PLACE OF INJURY — At home, term, street, lecture, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| 29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER <i>Kendall R. Faulkner MD</i> | | | | 29c. LICENSE NUMBER D25643 | | | | 29d. DATE SIGNED (Month, Day, Year) 7/17/95 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Dr. Kendall Faulkner 2300 Dulany Valley Road Towson, Maryland 21204 | | | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JUL 18 1995 | | | | 32. REGISTRAR'S SIGNATURE <i>John Andrew Koval</i> | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 21567

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) LOUIS FLEISCHER | | | | 2. DATE OF DEATH MONTH JULY DAY 14 , YEAR 1995 | | 3. TIME OF DEATH 1:30am M | |
| 4. SOCIAL SECURITY NUMBER 216-16-4836 | | 5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 87 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) FEB. 11, 1908 | |
| 9a. FACILITY NAME (If not institution, give street and number) PIKESVILLE NURSING HOME | | | | 9b. CITY, TOWN OR LOCATION OF DEATH PIKESVILLE | | 9c. COUNTY OF DEATH BALTIMORE | |
| 10a. STATE MARYLAND | | 10b. COUNTY N/A | | 10c. CITY, TOWN OR LOCATION BALTIMORE | | 10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 10e. STREET AND NUMBER 7001 FIELDCREST ROAD, APT. 2, 2nd FLOOR | | | | 10f. ZIP CODE 21215 | | 10g. CITIZEN OF WHAT COUNTRY? USA | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: WHITE | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (14 or 5+) N/A | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) SALESMAN | | 16b. KIND OF BUSINESS/INDUSTRY RETAIL - CLOTHING | | | |
| 17. FATHER'S NAME (First, Middle, Last) AHRON FLEISCHER | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) REBECCA BENESCH | | | |
| 19a. INFORMANT'S NAME (Type/Print) MR. ISRAEL MILTON FLEISCHER | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1619 GREENSPRING DRIVE LUTHERVILLE, MD 21093 | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) CHERNIGOVER | | 20c. LOCATION — City or Town, State 7-16-1995 ROSEDALE, MD | | 20d. DATE | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Jay Alay...</i> | | | | 22. NAME AND ADDRESS OF FACILITY SOL LEVINSON & BROS., INC. 6010 REISTERSTOWN ROAD BALTIMORE, MD 21215 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Sudden Cardiac Death DUE TO (OR AS A CONSEQUENCE OF): CVA Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST Aspiration Pneumonia DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/> | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 6 <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | | | 28e. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER <i>J. Salarraga</i> | | | | 29c. LICENSE NUMBER D35685 | | 29d. DATE SIGNED (Month, Day, Year) 7/14/95 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (Item 27) (Type, Print) Hoffberger 22 Sihar Hospital of Balto 21215 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JUL 18 1995 | | | | 32. REGISTRAR'S SIGNATURE <i>John Anderson</i> | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 5 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

blh

95 21568

1. FOR
STATE
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH REG. NO.

REG NO

TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | | |
|---|--|--|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) Enrique R George | | 2. DATE OF DEATH MONTH DAY YEAR July 11 1995 | | 3. TIME OF DEATH 0135 | |
| 4. SOCIAL SECURITY NUMBER 580-03-6434 | | 5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 52 YRS. | |
| 7. DATE OF BIRTH (Month, Day, Year) 2-7-43 | | 8. BIRTHPLACE (State or Foreign Country) Virgin Island | | | |
| 9a. FACILITY NAME (If not institution, give street and number) 1726 N. Gay Street | | 9b. CITY, TOWN OR LOCATION OF DEATH Baltimore | | 9c. COUNTY OF DEATH Baltimore | |
| 10a. STATE Maryland | | 10b. COUNTY Baltimore | | 10c. CITY, TOWN OR LOCATION Baltimore | |
| 10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 10e. STREET AND NUMBER 726 N. Gay Street | | 10f. ZIP CODE 21202 | |
| 10g. CITIZEN OF WHAT COUNTRY? USA | | 11. FATHER'S NAME (First, Middle, Last) Paul W. George | | 11. MOTHER'S NAME (First, Middle, Maiden Surname) Constancia | |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES 7/66 - 7/68 | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: Black | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) College | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Computer Technician | | 16b. KIND OF BUSINESS/INDUSTRY IBM | |
| 17a. INFORMANT'S NAME (Type/Print) Ahmed J. George | | 17b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) Balto. 5638 Stevens Forest Road Apt. 219 Md. 21045 | | 17c. LOCATION — City or Town, State Balto. Md. | |
| 18. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 19. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Garrison Forest Cemetery 7-20-95 | | 20. SIGNATURE OF FUNERAL SERVICE LICENSEE Willie Howell Sr. | |
| 21. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Arteriosclerotic Cardiovascular Disease | | 22. NAME AND ADDRESS OF FACILITY Unity Funeral Home 108 W. North Avenue | | 23. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| 24. IMMEDIATE CAUSE (Final disease or condition resulting in death) → | | 25. SEQUENTIAL CAUSE (Disease or injury that initiated events resulting in death) LAST | | 26. PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | |
| 27. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | 28. WAS AN AUTOPSY PERFORMED? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 29. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 30. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 31. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | 32. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined | |
| 33. DATE OF INJURY (Month, Day, Year) 28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 34. TIME OF INJURY 28b. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 35. DESCRIBE HOW INJURY OCCURRED 28c. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |
| 36. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 37. SIGNATURE AND TITLE OF CERTIFIER John L. Loke MD | | 38. LICENSE NUMBER O.C.M.E. | |
| 39. DATE SIGNED (Month, Day, Year) July 11 1995 | | 40. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) John L. Loke MD 111 Penn Street, Baltimore, Maryland 21201 | | 41. DATE FILED (Month, Day, Year) JUL 18 1995 | |
| 42. REGISTRAR'S SIGNATURE John L. Loke | | 43. REGISTRAR'S NAME (Type, Print) John L. Loke | | 44. REGISTRAR'S ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 111 Penn Street, Baltimore, Maryland 21201 | |

DMMH-16 Rev 1/89

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | | | |
|--|--|--|--|---|--|--|---|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) William E. Goodrich, Jr. | | | | 2. DATE OF DEATH MONTH DAY YEAR JUN 17 1995 | | 3. TIME OF DEATH 3:40 PM | | | | | |
| 4. SOCIAL SECURITY NUMBER 219-18-2274 | | 5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 70 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) Dec. 13, 1924 | | 8. BIRTHPLACE (State or Foreign Country) Maryland | | | |
| 9a. FACILITY NAME (If not institution, give street and number) 2401 Tionesta Road Apt. 3B | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Lansdown | | | 9c. COUNTY OF DEATH BALTIMORE | | | | |
| 10a. STATE Maryland | | 10b. COUNTY Baltimore | | 10c. CITY, TOWN OR LOCATION Lansdown | | | 10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | |
| 10e. STREET AND NUMBER 2401 Tionesta Road | | | | 10f. ZIP CODE 21227 | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | | | | | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES WW II | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | | 14. RACE — American Indian, Black, White, etc. Specify: White | | | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 9th | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Brick Layer | | | 16b. KIND OF BUSINESS/INDUSTRY Local #1 | | | | |
| 17. FATHER'S NAME (First, Middle, Last) William E. Goodrich, Sr. | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Marie L. Arnold | | | | | | | |
| 19a. INFORMANT'S NAME (Type/Print) Mrs. Lynn Abel | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 260 Ullman Road Pasadena, MD 21122 | | | | | | | |
| 20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION: Carroll Cremation Service July 20, 1995 | | DATE 7/20 | | 20c. LOCATION — City or Town, State Hampstead, MD | | | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Stephen M. Jones</i> | | | | 22. NAME AND ADDRESS OF FACILITY Loring Byers Funeral Directors Inc. 8728 Liberty Road Randallstown, MD 21133 | | | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → e. ARTERIO-SCLEROTIC CARDIOVASCULAR DISEASE DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | | | Approximate Interval Between Onset and Death | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Asbestosis | | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide | | | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED | |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| 29a. CERTIFY (Check one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | 29b. LICENSE NUMBER D11171 | | 29c. DATE SIGNED (Month, Day, Year) July 17, 1995 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type/Print) E. P. Williams, Jr. 485 Trade Ave. Catonsville 21228 MD | | | | | | | | 31. DATE FILED (Month, Day, Year) JUL 18 1995 | | | |
| 32. REGISTRAR'S SIGNATURE <i>John J. ...</i> | | | | | | | | | | | |

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

95 21570

1 - FOR
STATE
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|---|--|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last) CATHERINE GOLFORD | | | | 2. DATE OF DEATH MONTH JULY , DAY 16 , YEAR 1995 | | 3. TIME OF DEATH 2:12 P.M. | |
| 4. SOCIAL SECURITY NUMBER 217-07-8549 | | 5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 76 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) July 7, 1919 | |
| 9a. FACILITY NAME (If not institution, give street and number) Northwest Hospital Center | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Randallstown | | 9c. COUNTY OF DEATH Baltimore | |
| 10a. STATE Maryland | | | | 10b. COUNTY Baltimore | | 10c. CITY, TOWN OR LOCATION Randallstown | |
| 10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | | | | |
| 10e. STREET AND NUMBER 3409 Chapman Road | | | | 10f. ZIP CODE 21133 | | 10g. CITIZEN OF WHAT COUNTRY? United States | |
| 11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12th grade | | 15b. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Homemaker | | 16b. KIND OF BUSINESS/INDUSTRY own home | | | |
| 17. FATHER'S NAME (First, Middle, Last) William Thomas Higgs | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Sarah Elizabeth Howard | | | |
| 19a. INFORMANT'S NAME (Type/Print) Mr. Paul Kirby Galford | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4 Courtland Street Taneytown, MD 21787 | | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Good Shepherd Cemetery | | OATE 7/19 | | 20c. LOCATION — City or Town, State Ellicott City, MD | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Stephen M Jenkins | | | | 22. NAME AND ADDRESS OF FACILITY Loring Byers Funeral Directors, Inc. 8728 Liberty Road Randallstown, MD 21133 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → SEPTICEMIA (FUNGAL) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST <div style="display: flex; align-items: center;"> <div style="font-size: 4em; margin-right: 10px;">{</div> <div> RENAL FAILURE DIABETES MELLITUS TYPE II </div> </div> | | | | | | | Approximate Interval Between Onset and Death |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. CHRONIC OBSTRUCTIVE LUNG DISEASE | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | | | | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/> | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| 29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER SKing-Jul MD | | | | 29c. LICENSE NUMBER D 27157 | | 29d. DATE SIGNED (Month, Day, Year) JULY 16, 1995 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) RAYNOLD DEPESTRE NORTHWEST HOSPITAL CENTER | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JUL 18 1995 | | 32. REGISTRAR'S SIGNATURE John Andrew... | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | | | | | | | |
|--|--|--|---------------------------|---|--|--|--|---|---|---|--|--|--|--|--|
| 1. DECEASED'S NAME (First, Middle, Last) ANN G. GROSS | | | | 2. DATE OF DEATH MONTH JULY DAY 11 YEAR 1995 | | | | 3. TIME OF DEATH 8:41 P.M. | | | | | | | |
| 4. SOCIAL SECURITY NUMBER 489-46-8734 | | | | 5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 53 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) DEC 3, 1941 | | 8. BIRTHPLACE (State or Country) KS LEAVENWORTH | | | | | |
| 9a. FACILITY NAME (If not institution, give street and number) SINAI HOSPITAL | | | | | | 9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE | | | 9c. COUNTY OF DEATH N/A | | | | | | |
| RESIDENCE OF DECEASED | | | | | | | | | | | | | | | |
| 10a. STATE DE | | | 10b. COUNTY N/A | | | 10c. CITY, TOWN OR LOCATION WELLINGTON | | | 10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | | | |
| 10e. STREET AND NUMBER 1513 NORTH ADAMS | | | | | | 10f. ZIP CODE 19806 | | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | | | | | | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced | | | | 12. WAS DECEASED EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | | | 13. WAS DECEASED OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | | | 14. RACE — American Indian, Black, White, etc. Specify: WHITE | | | |
| 15. DECEASED'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (13 or 5+) 4 | | | | 16a. DECEASED'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) OFFICE MANAGER | | | | 16b. KIND OF BUSINESS/INDUSTRY ARCHITECTURE | | | | | | | |
| 17. FATHER'S NAME (First, Middle, Last) KENNETH C. GRIFFITHS | | | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) SARAH ANN AULL | | | | | | | | | |
| 19a. INFORMANT'S NAME (Type/Print) WILLIAM MAYFIELD GROSS | | | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1301 SPRUANCE RD. MONTELENEY CA. 95940 | | | | | | | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematorium, or other place) MACAPELAIN CEM. JULY 17, 95 LEXINGTON, MO. | | | | 20c. LOCATION — City or Town, State | | | | | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Thomas J. Skarda | | | | | | 22. NAME AND ADDRESS OF FACILITY SKARDA F.H. 2829 HUDON ST. BALTO., MD. 21224 | | | | | | | | | |
| 23. PART I. Enter the disease or diseases that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | | | | | | | | | |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | | | | a. METASTATIC LEIOMYOSARCOMA UTERUS/SEPSIS | | | | Approximate Interval Between Onset and Death YEARS/ | | | | | | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | b. DUE TO (OR AS A CONSEQUENCE OF): | | | | WKS. | | | | | | | |
| | | | | c. RESPIRATORY FAILURE | | | | DAYS | | | | | | | |
| | | | | d. DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | | | | | | | | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | | | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | | | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 6 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide | | | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED | | | | | |
| | | | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER Richard A. Chase, MD | | | | | | 29c. LICENSE NUMBER AS2402321RL | | 29d. DATE SIGNED (Month, Day, Year) 7-11-95 | | | | | | | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Richard A. Chase, MD Sinai Hospital of Baltimore | | | | | | | | | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JUL 18 1995 | | | | 32. REGISTRAR'S SIGNATURE John Andrew Randall | | | | | | | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

68760

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 21572

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|--|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) <u>Lawrence Gevins</u> | | | | 2. DATE OF DEATH MONTH <u>July</u> DAY <u>11</u> YEAR <u>1995</u> | | 3. TIME OF DEATH <u>0150 A.M.</u> | |
| 4. SOCIAL SECURITY NUMBER <u>098-05-7214</u> | | 5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) <u>74</u> YRS. | | 7. DATE OF BIRTH (Month, Day, Year) <u>JAN. 28, 1921</u> | |
| 9a. FACILITY NAME (If not institution, give street and number) <u>SINAI HOSPITAL</u> | | | | 9b. CITY, TOWN OR LOCATION OF DEATH <u>BALTIMORE</u> | | 9c. COUNTY OF DEATH <u>N/A</u> | |
| RESIDENCE OF DECEDENT | | | | | | | |
| 10a. STATE <u>MARYLAND</u> | | 10b. COUNTY <u>BALTIMORE</u> | | 10c. CITY, TOWN OR LOCATION <u>BALTIMORE</u> | | 10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| 10e. STREET AND NUMBER <u>3 STOCKMILL RD., APT. E</u> | | | | 10f. ZIP CODE <u>21208</u> | | 10g. CITIZEN OF WHAT COUNTRY? <u>USA</u> | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE YEAR OR DATES <u>WWII</u> | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: <u>WHITE</u> | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <u>College 3-4 or 5+</u> | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <u>SALES MANAGER</u> | | 16b. KIND OF BUSINESS/INDUSTRY <u>ENGINEERING</u> | |
| 17. FATHER'S NAME (First, Middle, Last) <u>DAVID GEVISENHEIT</u> | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) <u>TEMA COHEN</u> | | | |
| 19a. INFORMANT'S NAME (Type/Print) <u>MRS. ROSE GEVINS</u> | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>3 STOCKMILL RD., APT. E BALTO., MD 21208</u> | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <u>HEBREW YOUNG MEN 7/12/1995</u> | | 20c. LOCATION — City or Town, State <u>BALTIMORE, MD</u> | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <u>[Signature]</u> | | | | 22. NAME AND ADDRESS OF FACILITY <u>SOL LEVINSON & BROS., INC. 6010 REISTERTOWN RD. BALTO., MD 21215</u> | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <u>Coronary Artery Disease</u> DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST b. <u>Renal Failure</u> DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| c. <u>Diabetes Mellitus</u> DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| d. | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY <u>M</u> | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER <u>Craig Gold D.O.</u> | | | | 29c. LICENSE NUMBER <u>AS 2402321-CG-9919</u> | | 29d. DATE SIGNED (Month, Day, Year) <u>July 11, 1995</u> | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <u>Craig Gold D.O. 2401 West Belvedere Ave Baltimore Maryland 21215</u> | | | | | | | |
| 31. DATE FILED (Month, Day, Year) <u>JUL 18 1995</u> | | | | 32. REGISTRAR'S SIGNATURE <u>[Signature]</u> | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

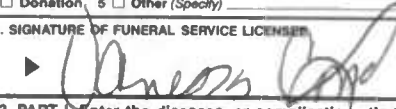
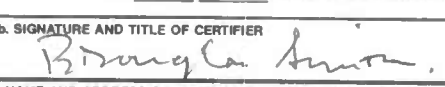
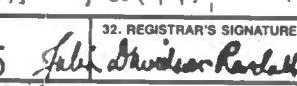
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 21573

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|--|--|---|--|--|---|
| 1. DECEDENT'S NAME (First, Middle, Last) JANIE MAE HOLLEY | | | | 2. DATE OF DEATH MONTH JULY DAY 15 YEAR 1995 | | 3. TIME OF DEATH 7:40 a M | |
| 4. SOCIAL SECURITY NUMBER 214-54-3118 | | 5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 57 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) MAR. 24, 1938 | |
| 9a. FACILITY NAME (If not institution, give street and number) THE JOHNS HOPKINS HOSPITAL | | | | 9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE CITY | | 9c. COUNTY OF DEATH n/a | |
| 10a. STATE MARYLAND | | | | 10b. COUNTY n/a | | 10c. CITY, TOWN OR LOCATION Baltimore | |
| 10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | | | | |
| 10e. STREET AND NUMBER 2420 E. EAGER STREET | | | | 10f. ZIP CODE 21205 | | 10g. CITIZEN OF WHAT COUNTRY? UNITED STATES | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: BLACK | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 10 TH College (1-4 or 5+) - | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) DOUBLE T - COOK | | 16b. KIND OF BUSINESS/INDUSTRY DINER | | | |
| 17. FATHER'S NAME (First, Middle, Last) WILLIE FOSTER | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) LILLIE MAE JONES | | | |
| 19a. INFORMANT'S NAME (Type/Print) DELORES HOLLEY | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2420 E. EAGER STREET, BALTIMORE, MD 21205 | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) KING MEMORIAL PARK 7-19 | | 20c. LOCATION — City or Town, State RANDALLSTOWN, MD | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE  | | | | 22. NAME AND ADDRESS OF FACILITY WM. C. MARCH FH.-1101 E. NORTH AVE. | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. ADENOCARCINOMA OF LUNG DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. | | | | | | | Approximate Interval Between Onset and Death YEARS |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DEHYDRATION | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | | | | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/> | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide 3 <input type="checkbox"/> Sudden 7 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28d. DESCRIBE NOW INJURY OCCURRED | | | | | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. SIGNATURE AND TITLE OF CERTIFIER  B. DOUGLAS SMITH, MD | | 29c. LICENSE NUMBER 247398 | | 29d. DATE SIGNED (Month, Day, Year) JULY 15 1995 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) B. DOUGLAS SMITH, MD ONCOLOGY CENTER 601 N WOLFE | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JUL 18 1995 | | 32. REGISTRAR'S SIGNATURE  | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 21574

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) GROVER HARRIS | | | | 2. DATE OF DEATH MONTH DAY YEAR JULY 10, 1995 | | 3. TIME OF DEATH 4:00 P. M. | |
| 4. SOCIAL SECURITY NUMBER 219-01-4357 | | 5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 86 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) July 12, 1908 | |
| 8. BIRTHPLACE (State or Foreign Country) N.C. | | | | 9a. FACILITY NAME (If not institution, give street and number) Stella Maris | | 9b. CITY, TOWN OR LOCATION OF DEATH Towson | |
| 9c. COUNTY OF DEATH Balto | | | | 10a. STATE Md | | 10b. COUNTY N/A | |
| 10c. CITY, TOWN OR LOCATION Balto | | | | 10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 10e. STREET AND NUMBER 3720 Yosemite Ave | |
| 10f. ZIP CODE 21215 | | | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | | 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | | |
| 14. RACE — American Indian, Black, White, etc. Specify: Black | | | | 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 6th College (14 or 5+) N/A | | | |
| 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Metal Sorter | | | | 16b. KIND OF BUSINESS/INDUSTRY Metal + Steel Co. | | | |
| 17. FATHER'S NAME (First, Middle, Last) Champion Harris | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Postelle | | | |
| 19a. INFORMANT'S NAME (Type/Print) Jessie M. West | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3720 Yosemite Ave Balto, Md 21215 | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Western Star Cem. 7/15/95 | | | |
| 20c. LOCATION — City or Town, State Catonsville, Md | | | | 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Glynis B. Scott | | | |
| 22. NAME AND ADDRESS OF FACILITY March A.H. West 4300 Wabash Ave | | | | 23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. End Stage COPD DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): Approximate Interval Between Onset and Death 3 years | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/> | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) Hospice | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | | | 28a. DATE OF INJURY (Month, Day, Year) 28b. TIME OF INJURY M 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO 28d. DESCRIBE HOW INJURY OCCURRED 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | 29b. SIGNATURE AND TITLE OF CERTIFIER Kendall R Faulkner | | | |
| 29c. LICENSE NUMBER D 25643 | | | | 29d. DATE SIGNED (Month, Day, Year) July 11, 1995 | | | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) DR. KENDALL FAULKNER 2300 DULANEY VALLEY RD. TOWSON, MD 21204 | | | | 31. DATE FILED (Month, Day, Year) JUL 18 1995 | | | |
| 32. REGISTRAR'S SIGNATURE John Anderson | | | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

P.O. BOX 68760

DIVISION OF VITAL RECORDS

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) JESSE WILLIAM HARPER, JR. | | | | 2. DATE OF DEATH MONTH 07 DAY 15 YEAR 1995 | | 3. TIME OF DEATH 16:18 M | |
| 4. SOCIAL SECURITY NUMBER 225-22-9287 | | 5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 68 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 07-23-1926 | |
| 9a. FACILITY NAME (If not institution, give street and number) UNIVERSITY HOSPITAL | | | | 9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE | | 9c. COUNTY OF DEATH N/A | |
| RESIDENCE OF DECEDENT | | | | | | | |
| 10a. STATE MARYLAND | | 10b. COUNTY ANNE ARUNDEL | | 10c. CITY, TOWN OR LOCATION LINTHICUM | | 10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 10e. STREET AND NUMBER 318 CHEDDINGTON ROAD | | | | 10f. ZIP CODE 21090 | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES WW II | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: WHITE | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 1 | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) ELECTRONIC TECHNICIAN | | 16b. KIND OF BUSINESS/INDUSTRY THEATER INDUSTRY | |
| 17. FATHER'S NAME (First, Middle, Last) JESSE WILLIAM HARPER, SR. | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) IOLA BATEMAN | | | |
| 19a. INFORMANT'S NAME (Type/Print) MARGUERITE HARPER | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 318 CHEDDINGTON ROAD, LINTHICUM, MARYLAND 21090 | | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) MEADOWRIDGE MEMORIAL PARK | | 20c. LOCATION — City or Town, State ELKRIDGE, MARYLAND | | 20d. DATE 7/19/95 | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Michael C. Zaffron</i> | | | | 22. NAME AND ADDRESS OF FACILITY SINGLETON FUNERAL HOME, 1 SECOND AVENUE, S.W. GLEN BURNIE, MARYLAND 21061 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. MASSIVE SUBDURAL HEMATOMA DUE TO (OR AS A CONSEQUENCE OF): b. FALL WITH HEAD TRAUMA DUE TO (OR AS A CONSEQUENCE OF): c. Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST d. THEADNE M. King MD e. D.C. APPROVED-OCME | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO | | | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) 7/19/95 | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED He fell backwards two steps at home. | | | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) AT HOME | | | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) 318 CHEDDINGTON RD. LINTHICUM, MD | | | | | | | |
| 29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER <i>John H. Joseph, M.D.</i> | | | | 29c. LICENSE NUMBER D 43371 | | 29d. DATE SIGNED (Month, Day, Year) 7/15/95 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) John H. Joseph, Herbert, MD, SHOCK TRAUMA CENTER, BALTIMORE, MD | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JUL 18 1995 | | | | 32. REGISTRAR'S SIGNATURE <i>John H. Joseph</i> | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1902

1903

1904

95 21576

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) LANITH HANSEN | | | | 2. DATE OF DEATH MONTH JULY DAY 17th YEAR 1995 | | 3. TIME OF DEATH 0830 AM | |
| 4. SOCIAL SECURITY NUMBER 216-01-3284 | | 5. SEX 1 <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 85 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) Nov. 5, 1909 | |
| 9a. FACILITY NAME (If not institution, give street and number) Northwest Hospital Center | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Randallstown | | 9c. COUNTY OF DEATH Baltimore | |
| 10a. STATE Maryland | | | | 10b. COUNTY Baltimore | | 10c. CITY, TOWN OR LOCATION Baltimore County | |
| 10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | | | | |
| 10e. STREET AND NUMBER 3512 Abbie Place | | | | 10f. ZIP CODE 21244 | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 11. MARITAL STATUS 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 Years | | 15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Machinist | | 16b. KIND OF BUSINESS/INDUSTRY National Lead Company | | | |
| 17. FATHER'S NAME (First, Middle, Last) Hans Carl Hansen | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Augusta Norgaard | | | |
| 19a. INFORMANT'S NAME (Type/Print) Mrs. Helen Mabe | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1124 Dairy Road Parkton, Maryland 21120 | | | |
| 20a. METHOD OF DISPOSITION 4 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Lake View Memorial Park | | DATE 7/20 | | 20c. LOCATION — City or Town, State Sykesville, Maryland | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Stephen M Jenkins</i> | | | | 22. NAME AND ADDRESS OF FACILITY Loring Byers Funeral Directors, Inc. 8728 Liberty Road Randallstown, MD 21133 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → PNEUMONIA DUE TO (OR AS A CONSEQUENCE OF): Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. | | | | | | Approximate interval Between Onset and Death 30 days | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DEMENTIA | | | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/> | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| | | 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) N/A | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER <i>K.S. Rao M.D.</i> | | | | 29c. LICENSE NUMBER 043462 | | 29d. DATE SIGNED (Month, Day, Year) JULY 17th 1995 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) K.S. Rao M.D. NORTH WEST HOSPITAL CENTER RANDALLSTOWN, MD | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JUL 18 1995 | | | | 32. REGISTRAR'S SIGNATURE <i>John Shuckler</i> | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760

BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 21577

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) Alonzo R. Hall, SR. | | | | 2. DATE OF DEATH MONTH July DAY 12 YEAR 1995 | | 3. TIME OF DEATH 9:00 P.M. | |
| 4. SOCIAL SECURITY NUMBER 215-84-3401 | | 5. SEX 1 <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 31 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) July 12, 1964 | |
| 9a. FACILITY NAME (If not Institution, give street and number) Laurel Regional Hospital | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Laurel | | 9c. COUNTY OF DEATH Howard | |
| 10a. STATE Maryland | | 10b. COUNTY Howard | | 10c. CITY, TOWN OR LOCATION Laurel | | 10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | |
| 10e. STREET AND NUMBER 9516 Earl Levy Court | | | | 10f. ZIP CODE 20723 | | 10g. CITIZEN OF WHAT COUNTRY? USA | |
| 11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: Black | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12th Grade | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Loader | | 16b. KIND OF BUSINESS/INDUSTRY Smelkinson Sysco | | | |
| 17. FATHER'S NAME (First, Middle, Last) Earl Hall | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Barbara Ann | | | |
| 19a. INFORMANT'S NAME (Type/Print) Brenda Hall | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9516 Earl Levy Court Laurel, Maryland 20723 | | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Meadowridge Cemetery | | DATE July | | 20c. LOCATION — City or Town, State Howard County, Maryland | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Rose M. Smith | | | | 22. NAME AND ADDRESS OF FACILITY Nutter Funeral Homes, Inc 2501 Gwynns Falls Parkway Baltimore, Maryland 21216 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | | a. Renal Failure and congestive | | | | | |
| | | b. Heart Failure | | | | | |
| | | c. Sepsis | | | | | |
| | | d. Acute Myeloblastic Leukemia | | | | | |
| Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| | | 28d. DESCRIBE NOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER [Signature] | | | | 29c. LICENSE NUMBER D 24721 | | 29d. DATE SIGNED (Month, Day, Year) 7/13/95 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Syed Sadeq 14800 4th St, Laurel MD 20707 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JUL 18 1995 | | 32. REGISTRAR'S SIGNATURE [Signature] | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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95 21578

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) Ruth Ann Heacock | | | | 2. DATE OF DEATH MONTH DAY YEAR July 16, 1995 | | 3. TIME OF DEATH 6:40 A M | |
| 4. SOCIAL SECURITY NUMBER 218-32-5209 | | 5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 59 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) June 26, 1936 | |
| 9a. FACILITY NAME (If not institution, give street and number) 3403 E. Joppa Road | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Parkville | | 9c. COUNTY OF DEATH Baltimore | |
| 10a. STATE Maryland | | | | 10b. COUNTY Baltimore | | 10c. CITY, TOWN OR LOCATION Parkville | |
| 10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | | | | |
| 10e. STREET AND NUMBER 3403 E. Joppa Road | | | | 10f. ZIP CODE 21234 | | 10g. CITIZEN OF WHAT COUNTRY? USA | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 11 College (1-4 or 5+) n/a | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Homemaker | | 16b. KIND OF BUSINESS/INDUSTRY Own Home | | | |
| 17. FATHER'S NAME (First, Middle, Last) Leonard Carl Breidenstein | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Ruth Bailey Rodgers | | | |
| 19a. INFORMANT'S NAME (Type/Print) Homer W. Heacock | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3403 E. Joppa Road, Baltimore, Maryland 21234 | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Trinity Episcopal Cemetery July 18 | | 20c. LOCATION — City or Town, State Long Green, Maryland | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Bryan W. Clary | | 22. NAME AND ADDRESS OF FACILITY Lemmon Funeral Home 10 W. Padonia Road, Timonium, MD 21093 | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. hypoxia DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST { b. Anasarca DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 8 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| | | 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | |
| | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER Patricia L. Cronin MD. | | | | 29c. LICENSE NUMBER D34750 | | 29d. DATE SIGNED (Month, Day, Year) 7-17-95. | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Patricia L. Cronin, M.D., 6305 Belair Road, S-A, Baltimore, MD 21206 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JUL 18 1995 | | | | 32. REGISTRAR'S SIGNATURE John Andrew Carroll | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|--|--|--|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) Gertrude Houdek | | | | 2. DATE OF DEATH MONTH DAY YEAR July 14, 1995 | | 3. TIME OF DEATH 12:05 M | |
| 4. SOCIAL SECURITY NUMBER 213-12-9963 | | 5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 79 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) August 28, 1915 | |
| 8. BIRTHPLACE (State or Foreign Country) PA. | | | | 9. COUNTY OF DEATH Baltimore | | | |
| 10a. STATE Md. | | | | 10b. COUNTY Baltimore | | 10c. CITY, TOWN OR LOCATION Essex | |
| 10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | 10e. STREET AND NUMBER 519 Franklin Ave. | | 10f. ZIP CODE 21221 | |
| 10g. CITIZEN OF WHAT COUNTRY? USA | | | | 11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | |
| 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | | | 14. RACE — American Indian, Black, White, etc. Specify: White | | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 6th College (1-4 or 5+) Chief | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Chief | | 16b. KIND OF BUSINESS/INDUSTRY n/a FOOD SERVICE | |
| 17. FATHER'S NAME (First, Middle, Last) Sylvester Thomas Ermine | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Katherine Dywer | | | |
| 19a. INFORMANT'S NAME (Type/Print) James Houdek Jr. | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11503 Pencewood Dr. Austin Texas 78750 | | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Oak Lawn Cemetery 7/18/95 | | 20c. LOCATION — City or Town, State Baltimore Md. | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE L. Terry Connelly | | | | 22. NAME AND ADDRESS OF FACILITY Connelly Funeral Home of Essex 300 Mace Ave. Baltimore Md. 21221 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Acute myocardial infarction Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST Acute gastrointestinal hemorrhage PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Cervical cancer | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/> | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | |
| 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | 28d. DESCRIBE HOW INJURY OCCURRED | | | |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER J. Crossan Donovan, M.D. | | | | 29c. LICENSE NUMBER D07632 | | 29d. DATE SIGNED (Month, Day, Year) 7-14-95 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) J. Crossan Donovan, M.D., 2112 Dundalk Ave., BALTO MD 21222 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JUL 18 1995 | | | | 32. REGISTRAR'S SIGNATURE John Charles Carroll | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 21580

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|---|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) JANET HERMAN | | | | 2. DATE OF DEATH MONTH JULY DAY 13 YEAR 1995 | | 3. TIME OF DEATH 8:14pm | |
| 4. SOCIAL SECURITY NUMBER 216-07-2847 | | 5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 94 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) JUNE 25, 1901 | |
| 9a. FACILITY NAME (If not institution, give street and number) SINAI HOSPITAL | | | | 9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE | | 9c. COUNTY OF DEATH N/A | |
| 10a. STATE MARYLAND | | | | 10b. COUNTY N/A | | 10c. CITY, TOWN OR LOCATION BALTIMORE | |
| 10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | | | | |
| 10e. STREET AND NUMBER 1 AMLEHT CT, APT. 1-C | | | | 10f. ZIP CODE 21215 | | 10g. CITIZEN OF WHAT COUNTRY? USA | |
| 11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: WHITE | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 4 College (1-4 or 5+) 4 | | 15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) BUYER | | 15b. KIND OF BUSINESS/INDUSTRY LADIES & CHILDREN CLOTHES | | | |
| 17. FATHER'S NAME (First, Middle, Last) JACOB HERMAN | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) ESTHER HARRIS | | | |
| 19a. INFORMANT'S NAME (Type/Print) MR. WILLARD HACKERMAN | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 SLADE AVE., APT. 806 BALTO., MD 21208 | | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) BNAT ISRAEL | | DATE 7-16-1995 | | 20c. LOCATION — City or Town, State BALTIMORE, MD | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i> | | | | 22. NAME AND ADDRESS OF FACILITY SOL LEVINSON & BROS., INC. 6010 REISTERSTOWN ROAD BALTIMORE, MD 21215 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → CONGESTIVE HEART FAILURE Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. DEATH RESULTED FROM DUE TO (OR AS A CONSEQUENCE OF): b. DEATH RESULTED FROM DUE TO (OR AS A CONSEQUENCE OF): c. DEATH RESULTED FROM DUE TO (OR AS A CONSEQUENCE OF): d. DEATH RESULTED FROM DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/> | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 28d. DESCRIBE NOW INJURY OCCURRED | | | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| 29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i> | | | | 29c. LICENSE NUMBER D-20492 | | 29d. DATE SIGNED (Month, Day, Year) 7/13/95 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 1777 REISTERSTOWN RD - PIMBORO MD 21202 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JUL 18 1995 | | | | 32. REGISTRAR'S SIGNATURE <i>[Signature]</i> | | | |

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION



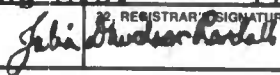
95-4136-510
blh

95 21581

1 - FOR
STATE
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) Eliot Purovost Hurd | | | | 2. DATE OF DEATH MONTH DAY YEAR July 15 1995 | | 3. TIME OF DEATH 1925 | |
| 4. SOCIAL SECURITY NUMBER 218-16-6608 | | 5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 72 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 10-25-1922 | |
| 8. BIRTHPLACE (State or Foreign Country) NEW YORK | | | | 9a. FACILITY NAME (If not institution, give street and number) 4100 N. Charles Street Apt. 802 | | 9b. CITY, TOWN OR LOCATION OF DEATH Baltimore | |
| 9c. COUNTY OF DEATH N/A | | | | 10a. STATE MARYLAND | | 10b. COUNTY N/A | |
| 10c. CITY, TOWN OR LOCATION BALTIMORE | | | | 10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | 10e. STREET AND NUMBER 4100 NORTH CHARLES ST. | |
| 10f. ZIP CODE 21218 | | | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | | 11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | | |
| 14. RACE — American Indian, Black, White, etc. Specify: WHITE | | | | 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 2YRS. College (1-4 or 5+) 2YRS. | | | |
| 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) CONSULTANT | | | | 16b. KIND OF BUSINESS/INDUSTRY BUSINESS CONSULTANT | | | |
| 17. FATHER'S NAME (First, Middle, Last) EDWARD A. HURD | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) ELSIE SMITH | | | |
| 19a. INFORMANT'S NAME (Type/Print) JANET HURD | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4100 NORTH CHARLES ST. BALTO., MD. 21218. | | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) ST. PAULS CEMETERY 7/95 | | 20c. LOCATION — City or Town, State CHESTERTOWN, MD. | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE  | | | | 22. NAME AND ADDRESS OF FACILITY HENRY W. JENKINS & SONS CO. 4905 YORK RD. BALTO., MD. 21212. | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Arteriosclerotic Cardiovascular Disease DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. | | | | | | Approximate Interval Between Onset and Death | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Asthma | | | | | | 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Field Inspection | |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO | | | | | | DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/> | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER  | | | | 29c. LICENSE NUMBER O.C.M.E. | | 29d. DATE SIGNED (Month, Day, Year) July 16 1995 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Theodore King M.D. 111 Penn Street, Baltimore, Maryland 21201 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JUL 18 1995 | | 32. REGISTRAR'S SIGNATURE  | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

BOX 68760

25

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 21582

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) LYNNE HUISWOUD | | | | 2. DATE OF DEATH MONTH DAY YEAR JULY 09 1995 | | 3. TIME OF DEATH 08:14 P M | |
| 4. SOCIAL SECURITY NUMBER N/A | | 5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs, last birthday) N/A YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 7-9-95 | |
| 8a. FACILITY NAME (If not institution, give street and number) GREATER BALTIMORE MEDICAL CENTER | | | | 8b. CITY, TOWN OR LOCATION OF DEATH TOWSON | | 8c. COUNTY OF DEATH BALTIMORE | |
| 10a. STATE MD | | 10b. COUNTY BALTIMORE | | 10c. CITY, TOWN OR LOCATION OWINGS MILLS | | 10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| 10e. STREET AND NUMBER 424 DOE MEADOW DRIVE | | | | 10f. ZIP CODE 21117 | | 10g. CITIZEN OF WHAT COUNTRY? USA | |
| 11. MARITAL STATUS 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: BLACK | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) N/A College (1-4 or 5+) N/A | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) N/A | | 16b. KIND OF BUSINESS/INDUSTRY N/A | | | |
| 17. FATHER'S NAME (First, Middle, Last) GARY STEVEN HUISWOUD | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) SHARON L. ROBINSON | | | |
| 19a. INFORMANT'S NAME (Type/Print) G.B.M.C. PATHOLOGY | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6701 NORTH CHARLES ST. TOWSON, MD 21204 | | | |
| 20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) GREENMOUNT CREMATORY 7/95 | | 20c. LOCATION — City or Town, State BALTO. MD | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE William R. Lawrence | | | | 22. NAME AND ADDRESS OF FACILITY HENRY W. JENKINS & SONS CO. 4905 YORK RD. BALTO., MD 21212 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Severe Immaturity. DUE TO (OR AS A CONSEQUENCE OF): b. Cardio Resp arrest. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | | Approximate interval between Onset and Death one hour 7 minutes |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER Saleem Al-Naber MD | | | | 29c. LICENSE NUMBER D33268 | | 29d. DATE SIGNED (Month, Day, Year) 7-11-95 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) SALEEM AL-NABER MD, Greater Baltimore Medical Center | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JUL 18 1995 | | | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 21583

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|---|--|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last) John Nolan Hall (JOHN NOLAN HALL) | | | | 2. DATE OF DEATH MONTH 7 DAY 7 YEAR 95 | | 3. TIME OF DEATH 2240 M | |
| 4. SOCIAL SECURITY NUMBER 117 22 2184 | | 5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 76 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 5-31-19 | |
| 8. BIRTHPLACE (State or Foreign Country) WEST VIRGINIA | | 9a. FACILITY NAME (If not institution, give street and number) Washington Co. Hospital | | 9b. CITY, TOWN OR LOCATION OF DEATH Hagerstown | | 9c. COUNTY OF DEATH Washington | |
| 10a. STATE WV | | 10b. COUNTY Berkeley | | 10c. CITY, TOWN OR LOCATION Hedgesville | | 10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 10e. STREET AND NUMBER Rt 1 Box 244A | | 10f. ZIP CODE 25427 | | 10g. CITIZEN OF WHAT COUNTRY? USA | | | |
| 11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: WHITE | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 4 | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) RESEARCH ENGINEER | | 16b. KIND OF BUSINESS/INDUSTRY RESEARCH DIV/HERCULES | | | |
| 17. FATHER'S NAME (First, Middle, Last) BURTON A. HALL | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) ADA L. HALL | | | |
| 19a. INFORMANT'S NAME (Type/Print) CONSTANCE J. HALL | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) RT. 1, BOX 244A, HEDGESVILLE, WV 25427 | | | |
| 20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) SMITHSBURG CREMATORY | | DATE 7/8 | | 20c. LOCATION — City or Town, State SMITHSBURG, MD | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Charles M. Brown | | | | 22. NAME AND ADDRESS OF FACILITY BROWN FUNERAL HOME, 327 W. KING ST. PO BOX 821, MARTINSBURG, WV 25401 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Acute myelogenous Leukemia DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. _____ DUE TO (OR AS A CONSEQUENCE OF): c. _____ DUE TO (OR AS A CONSEQUENCE OF): d. _____ | | | | | | | Approximate Interval Between Onset and Death 10 mks. |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. pneumonia | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | | | | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER Thomas B. Haywood MD | | | | 29c. LICENSE NUMBER D25714 | | 29d. DATE SIGNED (Month, Day, Year) 7/8/95 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Thomas B. Haywood MD, 354 M. H. St., Hagerstown MD 21742 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JUL 18 1995 | | | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 21584

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|---|--|--|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) Louis R. Heiss | | | | 2. DATE OF DEATH MONTH 7 DAY 9 YEAR 95 | | 3. TIME OF DEATH 1725 | |
| 4. SOCIAL SECURITY NUMBER 214038998 | | 5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 82 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 3-20-13 | |
| 8. BIRTHPLACE (State or Foreign Country) Dist. of Col. | | | | 9. FACILITY NAME (If not institution, give street and number) Anne Arundel Med Center | | 10. CITY, TOWN OR LOCATION OF DEATH Annapolis, md | |
| 11. COUNTY OF DEATH Anne Arundel | | | | 12. RESIDENCE OF DECEDENT 10a. STATE Maryland 10b. COUNTY Annapolis | | 13. CITY, TOWN OR LOCATION Annapolis | |
| 14. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input type="checkbox"/> NO | | | | 15. STREET AND NUMBER 2201 River Crescent Road | | 16. ZIP CODE 21401 | |
| 17. CITIZEN OF WHAT COUNTRY? U.S.A. | | | | 18. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 19. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | |
| 20. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO Specify: | | | | 21. RACE — American Indian, Black, White, etc. Specify: White | | 22. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) | |
| 23. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) ChemistSalesman | | | | 24. KIND OF BUSINESS/INDUSTRY Baxter Travel | | | |
| 25. FATHER'S NAME (First, Middle, Last) Louis Andrew Heiss | | | | 26. MOTHER'S NAME (First, Middle, Maiden Surname) Sarah Birkhead | | | |
| 27. INFORMANT'S NAME (Type/Print) Martha Heiss | | | | 28. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2201 River Crescent Road, Appapolis, MD., 21401 | | | |
| 29. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input checked="" type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 30. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) DATE | | 31. LOCATION — City or Town, State | |
| 32. SIGNATURE OF FUNERAL SERVICE LICENSEE Ronald Wade, Dir. | | | | 33. NAME AND ADDRESS OF FACILITY State Anatomy Board 655 W. Baltimore St., Baltimore, MD. 21201 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Acute myocardial Infarction DUE TO (OR AS A CONSEQUENCE OF): a. Acute myocardial Infarction b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): Approximately Interval Between Onset and Death: minutes | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | |
| 34. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 35. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 36. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined | | 37. DATE OF INJURY (Month, Day, Year) | | 38. TIME OF INJURY M | | 39. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 37. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 38. DESCRIBE HOW INJURY OCCURRED | | | | | |
| 39. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | 39. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | |
| 40. SIGNATURE AND TITLE OF CERTIFIER [Signature] | | | | 41. LICENSE NUMBER D12452 | | 42. DATE SIGNED (Month, Day, Year) 7/6/95 | |
| 43. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) | | | | | | | |
| 44. DATE FILED (Month, Day, Year) JUL 17 1995 | | | | 45. REGISTRAR'S SIGNATURE [Signature] | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) BRIAN ANTHONY JOHNSON | | | | 2. DATE OF DEATH MONTH 07 DAY 16 YEAR 1995 | | 3. TIME OF DEATH 02:36 A M | |
| 4. SOCIAL SECURITY NUMBER 218-02-8553 | | 5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 21 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) APRIL 21, 1974 | |
| 8. BIRTHPLACE (State or Foreign Country) BALTIMORE, MD | | | | 9a. FACILITY NAME (If not institution, give street and number) JOHNS HOPKINS HOSPITAL | | 9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE CITY | |
| 9c. COUNTY OF DEATH n/a | | | | 10a. STATE MARYLAND | | 10b. COUNTY n/a | |
| 10c. CITY, TOWN OR LOCATION BALTIMORE | | | | 10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | 10e. STREET AND NUMBER 2214 AIKEN STREET | |
| 10f. ZIP CODE 21218 | | | | 10g. CITIZEN OF WHAT COUNTRY? UNITED STATES | | 11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | | |
| 14. RACE — American Indian, Black, White, etc. Specify: BLACK | | | | 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (9-12) 11 th College (1-4 or 5+) - | | | |
| 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) unemployed | | | | 16b. KIND OF BUSINESS/INDUSTRY never worked | | | |
| 17. FATHER'S NAME (First, Middle, Last) ERIC THOMAS GOINES | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) ANGELA JOHNSON | | | |
| 19a. INFORMANT'S NAME (Type/Print) ANGELA JOHNSON | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2214 AIKEN STREET, BALTIMORE, MD 21218 | | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) WESTERN STAR CEMETERY 7-20 | | | |
| 20c. LOCATION — City or Town, State CATONSVILLE, MD | | | | 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | | | |
| 22. NAME AND ADDRESS OF FACILITY WM. C. MARCH FH. 1101 E. NORTH AVENUE | | | | 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Multiple Gunshot Wounds DUE TO (OR AS A CONSEQUENCE OF): Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST DUE TO (OR AS A CONSEQUENCE OF): PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | |
| 24a. WAS AN AUTOPSY PERFORMED? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | |
| 27. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | | | 28a. DATE OF INJURY (Month, Day, Year) 7/16/95 | | | |
| 28b. TIME OF INJURY 0155 M | | | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | |
| 28d. DESCRIBE HOW INJURY OCCURRED Subject shot | | | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) street | | | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) 1800 North Collington | | | | 29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER | | | | 29c. LICENSE NUMBER O.C.M.E. | | | |
| 29d. DATE SIGNED (Month, Day, Year) 07 16 1995 | | | | 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) THEODORE M. Miley | | | |
| 31. DATE FILED (Month, Day, Year) JUL 18 1995 | | | | 32. REGISTRAR'S SIGNATURE | | | |

95 21586

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|---|--|---|--|
| 1. DECEASED'S NAME (First, Middle, Last) JOSEPH JACKSON Sr. | | | | 2. DATE OF DEATH MONTH JULY DAY 14 YEAR 1995 | | 3. TIME OF DEATH 2:30 PM | |
| 4. SOCIAL SECURITY NUMBER 217-07-5469 | | 5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 77 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) Jan 26, 1918 | |
| 8. BIRTHPLACE (State or Foreign Country) md | | | | 9. FACILITY NAME (If not institution, give street and number) SINAI HOSPITAL OF BALTIMORE | | 10. CITY, TOWN OR LOCATION OF DEATH Balto | |
| 11. RESIDENCE OF DECEASED | | | | 12. COUNTY OF DEATH N/A | | 13. STATE md | |
| 14. STATE md | | 15. COUNTY N/A | | 16. CITY, TOWN OR LOCATION Balto | | 17. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | |
| 18. STREET AND NUMBER 6634 Dalton Dr. | | | | 19. ZIP CODE 21207 | | 20. CITIZEN OF WHAT COUNTRY? U.S.A | |
| 21. MARITAL STATUS <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Divorced | | 22. WAS DECEASED EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES 5-15-45 thru 4-26-46 | | 23. WAS DECEASED OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO Specify: | | 24. RACE — American Indian, Black, White, etc. Specify: Black | |
| 25. DECEASED'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 8th | | 26. DECEASED'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Chauffeur | | 27. KIND OF BUSINESS/INDUSTRY Clothing | | 28. FATHER'S NAME (First, Middle, Last) Chesapeake Jackson | |
| 29. MOTHER'S NAME (First, Middle, Maiden Surname) Sadie | | 30. INFORMANT'S NAME (Type/Print) Jacqueline Richardson | | 31. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6634 Dalton Dr. Balto, md 21207 | | 32. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | |
| 33. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Garrison Forest Veteran | | 34. DATE 7/14/95 | | 35. LOCATION — City or Town, State owing mills, md | | 36. SIGNATURE OF FUNERAL SERVICE LICENSEE W. E. Elmer | |
| 37. NAME AND ADDRESS OF FACILITY Marion F. H. West | | 38. ADDRESS 4300 Wabash Ave | | 39. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. PNEUMONIA DUE TO (OR AS A CONSEQUENCE OF): | | 40. IMMEDIATE CAUSE (Final disease or condition resulting in death) → | |
| 41. SEQUENTIALLY list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST LUNG CANCER DUE TO (OR AS A CONSEQUENCE OF): | | 42. PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. CHRONIC OBSTRUCTIVE PULMONARY DISEASE, HYPERTENSION, DIABETES MELLITUS, RENAL INSUFFICIENCY | | 43. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/> | | 44. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 45. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 46. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 47. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | 48. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | |
| 49. DATE OF INJURY (Month, Day, Year) | | 50. TIME OF INJURY M | | 51. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 52. DESCRIBE HOW INJURY OCCURRED | |
| 53. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 54. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | 55. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 56. SIGNATURE AND TITLE OF CERTIFIER John W. Butler MD | |
| 57. LICENSE NUMBER AS 2402321-JB-9912 | | 58. DATE SIGNED (Month, Day, Year) JULY 14, 1995 | | 59. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) JOHN BUTLER MD SINAI HOSPITAL 2401 W. BELVEDERE, BALTIMORE, MD 21215 | | 60. DATE FILED (Month, Day, Year) JUL 18 1995 | |
| 61. REGISTRAR'S SIGNATURE John W. Butler | | 62. REGISTRAR'S SIGNATURE | | 63. REGISTRAR'S SIGNATURE | | 64. REGISTRAR'S SIGNATURE | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.


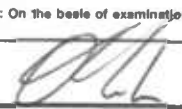
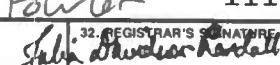
95-4143-510
B.K.S

95 21587

1 - FOR
STATE
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | | | | |
|---|--|--|--|---|---------------------|---|---|---|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) CLIFTON JORDAN | | | | 2. DATE OF DEATH MONTH JULY DAY 16 , YEAR 1995 | | 3. TIME OF DEATH 0908 A M | | | | | | |
| 4. SOCIAL SECURITY NUMBER 213-18-3094 | | 5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 76 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) July 24, 1918 | | 8. BIRTHPLACE (State or Foreign Country) Maryland | | | | |
| 9a. FACILITY NAME (If not institution, give street and number) 2204 PENROSE AVENUE | | | | 9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE CITY | | | 9c. COUNTY OF DEATH N/A | | | | | |
| RESIDENCE OF DECEDENT | | | | | | | | | | | | |
| 10a. STATE Maryland | | 10b. COUNTY Baltimore | | 10c. CITY, TOWN OR LOCATION Baltimore | | | 10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | | | | |
| 10e. STREET AND NUMBER 2204 Penrose Avenue | | | | 10f. ZIP CODE 21223 | | 10g. CITIZEN OF WHAT COUNTRY? USA | | | | | | |
| 11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE YEAR OR DATES WW II | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | | 14. RACE — American Indian, Black, White, etc. Specify: Black | | | | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) 8th Grade | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Garage Attendant | | | 16b. KIND OF BUSINESS/INDUSTRY Horizon House | | | | | |
| 17. FATHER'S NAME (First, Middle, Last) Morris Jordan | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Helen Jones | | | | | | | | |
| 19a. INFORMANT'S NAME (Type/Print) Camille Jordan | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2204 Penrose Ave. Baltimore, Maryland 21223 | | | | | | | | |
| 20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Crematory - Metro | | | OATE 7/17 | | 20c. LOCATION — City or Town, State Baltimore, Maryland | | | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE  | | | | 22. NAME AND ADDRESS OF FACILITY Nutter Funeral Homes Inc. 2501 Gwynn Falls PKY Baltimore, Md. 21216 | | | | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Atherosclerosis cardiovascular disease DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | Approximate Interval Between Onset and Death | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO Partial | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | | | | |
| 27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED | | | | |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | | | | |
| 29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER  | | | | 29c. LICENSE NUMBER O.C.M.E | | 29d. DATE SIGNED (Month, Day, Year) JULY 17, 1995 | | | | | | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) David R. Fowler 111 Penn Street, Baltimore, Maryland 21201 | | | | | | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JUL 18 1995 | | | | 32. REGISTRAR'S SIGNATURE  | | | | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

68760

2

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 21589

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|---|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) RUBY JACOBS | | | | 2. DATE OF DEATH MONTH JULY DAY 3 YEAR 1995 | | 3. TIME OF DEATH 11:00 P. | |
| 4. SOCIAL SECURITY NUMBER 259-07-9510 | | 5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 73 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) MAY 20, 1922 | |
| 8. BIRTHPLACE (State or Foreign Country) GA. | | | | 9. FACILITY NAME (If not institution, give street and number) BRIGHTWOOD N.H. | | 10. CITY, TOWN OR LOCATION OF DEATH N/A | |
| 11. RESIDENCE OF DECEDENT 10a. STATE MD. 10b. COUNTY BALTIMORE | | | | 10c. CITY, TOWN OR LOCATION N/A | | 10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| 10e. STREET AND NUMBER 515 BRIGHTFIELD RD. | | | | 10f. ZIP CODE 21022 | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: WHITE | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 12 | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) SUPERVISOR | | 16b. KIND OF BUSINESS/INDUSTRY SOCIAL SEC. | | | |
| 17. FATHER'S NAME (First, Middle, Last) N/A | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) N/A | | | |
| 19a. INFORMANT'S NAME (Type/Print) ARTHUR DRAGER | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5 LIGHT ST. SUITE 510 BALTO., MD. 21202 | | | |
| 20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 6 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematorium or other place) EXTONDALENT MEMORIAL PARK CEM. 7-7-95 | | 20c. LOCATION — City or Town, State GAINESVILLE, GA. | | 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Thomas J. Skarda Jr. | |
| 22. NAME AND ADDRESS OF FACILITY SKARDA F.H. 2829 HUDSON ST. BALTO., MD. 21224 | | 23. PART I. Enter the diseases or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Brain Tumor DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. Brain Tumor DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): | | | | Approximate interval Between Onset and Death Months | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/> | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER Isabel C. O. Reid | | | | 29c. LICENSE NUMBER D08358 | | 29d. DATE SIGNED (Month, Day, Year) 7/4/95 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) GRACIA PATRICIO 8903 HARFORD ROAD BALTO. MD 21234 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JULY 4 1995 | | | | 32. REGISTRAR'S SIGNATURE John H. ... | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

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IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|---|---|--|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last) WARING SWEN JUSTIS, Sr. | | | | 2. DATE OF DEATH MONTH DAY YEAR July 14, 1995 | | 3. TIME OF DEATH 5:05 A. M. | |
| 4. SOCIAL SECURITY NUMBER 215-14-8032 | | 5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | 6. AGE (In yrs. last birthday) 74 YRS. | 7. DATE OF BIRTH (Month, Day, Year) Nov. 27, 1920 | | 8. BIRTHPLACE (State or Foreign Country) Maryland | |
| 9a. FACILITY NAME (If not institution, give street and number) Stella Maris | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Towson, MD | | 9c. COUNTY OF DEATH Baltimore | |
| RESIDENCE OF DECEDENT | | | | | | | |
| 10a. STATE MD | | 10b. COUNTY Baltimore | | 10c. CITY, TOWN OR LOCATION Towson | | 10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| 10e. STREET AND NUMBER 500 Dogwood Lane 2500 Dulaney Valley Rd. Towson, MD | | | | 10f. ZIP CODE 21286 21204 | | 10g. CITIZEN OF WHAT COUNTRY? USA | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES WWII | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Salesman | | 16b. KIND OF BUSINESS/INDUSTRY Commercial Oils | | | |
| 17. FATHER'S NAME (First, Middle, Last) William Marcus Justis | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Sarah Elizabeth Starling | | | |
| 19a. INFORMANT'S NAME (Type/Print) Mrs. Myrtle E. Justis | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 500 Dogwood Lane, Towson, MD 21286 | | | |
| 20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Metro Crematory July 14, 1995 | | 20c. LOCATION — City or Town, State Catonsville, MD | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Bryan W. Clary | | | | 22. NAME AND ADDRESS OF FACILITY Lemmon Funeral Home 10 W. Padonia Rd., Timonium, MD 21093 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. CANCER OF THE ESOPHAGUS DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | | Approximate Interval Between Onset and Death 7 mos. |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | | | | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/> | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) Hospice | | | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER Kendall R Faulkner | | | | 29c. LICENSE NUMBER D25643 | | 29d. DATE SIGNED (Month, Day, Year) 7/14/95 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) DR. KENDALL FAULKNER 2300 DULANEY VALLEY RD., TOWSON, MD 21204 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JUL 18 1995 | | | | 32. REGISTRAR'S SIGNATURE John Davidson Randall | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 21591

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|--|--|--|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) J. Wynne JONES III | | | | 2. DATE OF DEATH MONTH DAY YEAR July 14 1995 | | 3. TIME OF DEATH 9 pm. M | |
| 4. SOCIAL SECURITY NUMBER 217-46-1717 | | 5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 48 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) Dec. 22, 1946 | |
| 8. BIRTHPLACE (State or Foreign Country) Maryland | | | | 9a. FACILITY NAME (If not institution, give street and number) Franklin Square Hospital | | 9b. CITY, TOWN OR LOCATION OF DEATH Rossville | |
| 9c. COUNTY OF DEATH Baltimore County | | | | 10a. STATE Maryland | | 10b. COUNTY Baltimore County | |
| 10c. CITY, TOWN OR LOCATION Baltimore | | | | 10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 10e. STREET AND NUMBER 5010 Kenwood Avenue | |
| 10f. ZIP CODE 21206 | | | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | | 11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 2 yrs. | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Short Order Cook | | 16b. KIND OF BUSINESS/INDUSTRY Restaurant | |
| 17. FATHER'S NAME (First, Middle, Last) J. Wynne Jones Jr. | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Mary Olive Virginia Scull | | | |
| 19a. INFORMANT'S NAME (Type/Print) Madaline Anna Jones | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5010 Kenwood Avenue, Baltimore, Maryland 21206 | | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Gardens of Faith Cemetery 7-18 | | 20c. LOCATION — City or Town, State Baltimore, Md. | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Kathleen M. Murphy | | | | 22. NAME AND ADDRESS OF FACILITY John C. Miller, Inc. Baltimore, Maryland 21206 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Hepatitis Etiology Not Determined DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): Approximate Interval Between Onset and Death 4 weeks | | | | | | 24a. WAS AN AUTOPSY PERFORMED? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO | | | | | | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | 27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | |
| 28a. DATE OF INJURY (Month, Day, Year) | | | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | 29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER Kima Long MD | | | | 29c. LICENSE NUMBER R.D. 1905 | | 29d. DATE SIGNED (Month, Day, Year) July 15, 1995 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Rima Couzi, MD 9000 Franklin Square Drive Baltimore, MD 21237 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JUL 18 1995 John P. [Signature] | | | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

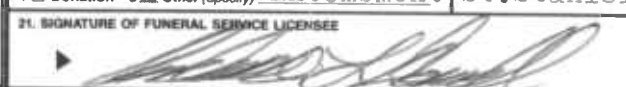
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 21592

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) JULIA F. KRAWCZYK | | | | 2. DATE OF DEATH MONTH DAY YEAR July 16, 1995 | | 3. TIME OF DEATH 1st. 7:30 A M | |
| 4. SOCIAL SECURITY NUMBER 218-60-7665 | | 5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 82 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) June 16, 1913 | |
| 9a. FACILITY NAME (If not institution, give street and number) 1927 Crouse Road | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Forest Hill | | 9c. COUNTY OF DEATH Harford County | |
| RESIDENCE OF DECEDENT | | | | | | | |
| 10a. STATE Maryland | | 10b. COUNTY Harford Co. | | 10c. CITY, TOWN OR LOCATION Forest Hill | | 10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| 10e. STREET AND NUMBER 1927 Crouse Road | | | | 10f. ZIP CODE 21050 | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 10 College (1-4 or 5+) 0 | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Home maker | | 16b. KIND OF BUSINESS/INDUSTRY - | | | |
| 17. FATHER'S NAME (First, Middle, Last) Marion Maciejewski | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Stella Malanowski | | | |
| 19a. INFORMANT'S NAME (Type/Print) Loretta Rychlak | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1927 Crouse Rd. Forest Hill, Md. 21050 | | | |
| 20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input checked="" type="checkbox"/> Other (Specify) Entombment | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) St. Stanislaus Cemetery 7/19/95 | | 20c. LOCATION — City or Town, State Balto. Maryland | | 20d. DATE 7/19/95 | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE  | | | | 22. NAME AND ADDRESS OF FACILITY George A. Weber & Sons Inc. 705 S. Ann St. Balto. Md. 21231 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | | a. Myocardial infarction DUE TO (OR AS A CONSEQUENCE OF): | | | | | Approximate Interval Between Onset and Death 1 hr |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | b. ASCVD DUE TO (OR AS A CONSEQUENCE OF): | | | | | 1 yr |
| | | c. _____ DUE TO (OR AS A CONSEQUENCE OF): | | | | | |
| | | d. _____ DUE TO (OR AS A CONSEQUENCE OF): | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Stroke | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| | | 28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28e. DESCRIBE HOW INJURY OCCURRED | | | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER James F. Carow M.D. | | | | 29c. LICENSE NUMBER 034915 | | 29d. DATE SIGNED (Month, Day, Year) 7-17-95 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) James F. Carow M.D. 2801 Hudson St. Balto. Md. 21224 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JUL 18 1995 | | | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

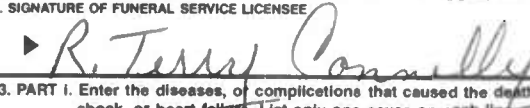

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 21593

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | | | | | | |
|---|--|--|--|---|--|--|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) Edward KRATFEL | | | | 2. DATE OF DEATH MONTH July DAY 15 , 1995 YEAR | | | | 3. TIME OF DEATH 11:26 P.M. | |
| 4. SOCIAL SECURITY NUMBER 216-34-5100 | | 5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F | 6. AGE (In yrs. last birthday) 57 YRS. | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS. HOURS MIN. | | 7. DATE OF BIRTH Month, Day, Year Feb. 2, 1938 | |
| 9a. FACILITY NAME (If not institution, give street and number) Franklin Square Hospital | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Rossville | | | | 9c. COUNTY OF DEATH Baltimore County | |
| RESIDENCE OF DECEDENT | | | | | | | | | |
| 10a. STATE Md. | | 10b. COUNTY Baltimore | | 10c. CITY, TOWN OR LOCATION Essex | | | | 10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 10e. STREET AND NUMBER 956 N. Marlyn Ave. | | | | 10f. ZIP CODE 21221 | | 10g. CITIZEN OF WHAT COUNTRY? USA | | | |
| 11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | | | 14. RACE — American Indian, Black, White, etc. Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 4yrs | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Mechanical Engineer | | 16b. KIND OF BUSINESS/INDUSTRY Consolidated Instrument | | | | | |
| 17. FATHER'S NAME (First, Middle, Last) Francis Kratfel | | | | 16. MOTHER'S NAME (First, Middle, Maiden Surname) Anna Wysocki | | | | | |
| 19a. INFORMANT'S NAME (Type/Print) Jane Kratfel | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 956 N. Marlyn Ave. Baltimore Md. 21221 | | | | | |
| 20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Metro Crematory Inc. 7/19/95 | | DATE | | 20c. LOCATION — City or Town, State Baltimore Md. | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE  | | | | 22. NAME AND ADDRESS OF FACILITY Connelly Funeral Home of Essex 300 Mace Ave. Baltimore Md. 21221 | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Ventricular Fibrillation DUE TO (OR AS A CONSEQUENCE OF): b. Coronary Artery Disease DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | | | Approximate interval Between Onset and Death Immediate Years (14) | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/> | | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO | | | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURED | |
| | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER  | | | | 29c. LICENSE NUMBER D 22234 | | 29d. DATE SIGNED (Month, Day, Year) 7/16/95 | | | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Rodney Johnson, MD 9101 Franklin Square Drive Baltimore, MD 21237 | | | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JUL 18 1995 | | | | 32. REGISTRAR'S SIGNATURE  | | | | | |

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

P.O. BOX 68760

10

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 21594

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|---|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) Fred Lampkin | | | | 2. DATE OF DEATH MONTH JULY DAY 13TH YEAR 1995 | | 3. TIME OF DEATH 1:30 A M | |
| 4. SOCIAL SECURITY NUMBER 148-09-5365 | | 5. SEX 1 M 2 F | | 6. AGE (In yrs. last birthday) 87 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 10-15-06 | |
| 9a. FACILITY NAME (If not institution, give street and number) Union Memorial Hospital | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Baltimore City | | 9c. COUNTY OF DEATH N/A. | |
| RESIDENCE OF DECEDENT | | | | 10c. CITY, TOWN OR LOCATION | | 10d. INSIDE CITY LIMITS? 1 YES 2 NO | |
| 10a. STATE md. | | 10b. COUNTY N/A | | 10c. CITY, TOWN OR LOCATION BALTO. | | 10d. INSIDE CITY LIMITS? 1 YES 2 NO | |
| 10e. STREET AND NUMBER 2658 HARFORD RD | | | | 10f. ZIP CODE 21218 | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 11. MARITAL STATUS 3 Widowed 4 Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 YES 2 NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: BLACK | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (9-12) | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Corpor | | 16b. KIND OF BUSINESS/INDUSTRY Heinz Catup | | | |
| 17. FATHER'S NAME (First, Middle, Last) Alexander Lampkin | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Betty Lampkin | | | |
| 19a. INFORMANT'S NAME (Type/Print) Georgia Stein | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2658 HARFORD RD. BALTO. MD 21218 | | | |
| 20a. METHOD OF DISPOSITION 1 Burial 2 Cremation 3 Removal from State 4 Donation 6 Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Voshell Cem July BALTO. MD | | 20c. LOCATION — City or Town, State | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Patricia Betts | | | | 22. NAME AND ADDRESS OF FACILITY Betts Funeral Home 21218 1125 N. CAROLINE ST BALTO MD | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. RESPIRATORY & CARDIAC ARREST DUE TO (OR AS A CONSEQUENCE OF): b. CHRONIC RENAL FAILURE DUE TO (OR AS A CONSEQUENCE OF): c. PROSTATE CANCER DUE TO (OR AS A CONSEQUENCE OF): d. Approximate Interval Between Onset and Death 1-2 mins 3 months 3 months | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ISCHEMIC COLITIS | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 Inpatient 2 ER/Outpatient 3 DOA OTHER: 4 Nursing Home 5 Residence 6 Other (Specify) | | | | | |
| 27. MANNER OF DEATH 1 Natural 2 Accident 3 Suicide 4 Homicide 5 Pending Investigation 6 Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 YES 2 NO | |
| 28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28d. DESCRIBE HOW INJURY OCCURRED | | | | | |
| 29a. CERTIFIER (Check only one) 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. SIGNATURE AND TITLE OF CERTIFIER Arvinder K. Bains | | 29c. LICENSE NUMBER AT 2438746 (DEA#) | | 29d. DATE SIGNED (Month, Day, Year) 7/13/95 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) ARVINDER K BAINS, DEPT OF MEDICINE, UNION MEMORIAL HOSPITAL | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JUL 18 1995 | | 32. REGISTRAR'S SIGNATURE John Andrew Randall | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 21595

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|---|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) BARBARA ann LYDE | | | | 2. DATE OF DEATH MONTH DAY YEAR JULY 14, 1995 | | 3. TIME OF DEATH 21:54 M | |
| 4. SOCIAL SECURITY NUMBER 217-54-0909 | | 5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | 6. AGE (In yrs. last birthday) 45 YRS. | 7. DATE OF BIRTH (Month, Day, Year) APR. 5, 1950 | | 8. BIRTHPLACE (State or Foreign Country) BALTIMORE, MD | |
| 9a. FACILITY NAME (If not institution, give street and number) THE JOHNS HOPKINS HOSPITAL | | | | 9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE CITY | | 9c. COUNTY OF DEATH n/a | |
| 10a. STATE MARYLAND | | | | 10b. COUNTY n/a | | 10c. CITY, TOWN OR LOCATION Baltimore | |
| 10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | 10e. STREET AND NUMBER 1323 Silverthorne Road | | | |
| 10f. ZIP CODE 21239 | | | | 10g. CITIZEN OF WHAT COUNTRY? UNITED STATES | | | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: BLACK | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (9-12) College (1-4 or 5+) G.E.D. - | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) COMPUTER TECH. | | 16b. KIND OF BUSINESS/INDUSTRY STATE of MARYLAND | | | |
| 17. FATHER'S NAME (First, Middle, Last) ISAAC MACKLEY | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) MILDRED ROBINSON | | | |
| 19a. INFORMANT'S NAME (Type/Print) WILLOUIS LYDE JR. | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1323 Silverthorne Road, Baltimore, MD 21239 | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Cedar Hill Cemetery 7-20 | | 20c. LOCATION — City or Town, State Anne Arundel CO, MD | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | | | | 22. NAME AND ADDRESS OF FACILITY WM. C. MARCH FH.-1101 E. NORTH AVENUE | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <u>subarachnoid hemorrhage</u> DUE TO (OR AS A CONSEQUENCE OF): b. <u>ant. communicating artery aneurysm</u> DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>possible sepsis</u> | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/> | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28e. DESCRIBE HOW INJURY OCCURRED | | | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER | | | | 29c. LICENSE NUMBER N2445 | | 29d. DATE SIGNED (Month, Day, Year) July 14, 1995 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) G. Dike, MD - Johns Hopkins Path 509 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JUL 18 1995 | | | | 32. REGISTRAR'S SIGNATURE | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95-3850-510

B.K.S

ITEMS: 8-19b, PER MEO FILM G-728 10/19/95 t.t

ITEMS: 23 PART I, 27, PER MEO FILM G-726 8/7/95 t.t

95 21596

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

| | | | | | | | |
|--|--|--|--|--|--|--|---|
| 1. DECEDENT'S NAME (First, Middle, Last) CHARLES LONESOME | | | | 2. DATE OF DEATH MONTH JULY DAY 03 YEAR 1995 | | 3. TIME OF DEATH 0855 A M | |
| 4. SOCIAL SECURITY NUMBER | | 5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 39 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 9-18-55 | |
| 9a. FACILITY NAME (If not institution, give street and number) 840 PARK AVENUE APT.#3-B | | | | 9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE CITY | | 9c. COUNTY OF DEATH MARYLAND | |
| 10a. STATE MARYLAND | | | | 10b. COUNTY BALTIMORE | | 10c. CITY, TOWN OR LOCATION BALTIMORE | |
| 10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | | | 10e. STREET AND NUMBER 311 E. 28TH STREET | | 10f. ZIP CODE 21218 | |
| 10g. CITIZEN OF WHAT COUNTRY? USA | | | | 11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | |
| 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | | | 14. RACE — American Indian, Black, White, etc. Specify: Black | | 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 10TH College (1-4 or 5+) Colege | |
| 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) CARPENTER | | | | 16b. KIND OF BUSINESS/INDUSTRY CARPENTRY | | | |
| 17. FATHER'S NAME (First, Middle, Last) KENNETH MOSES LONESOME | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) THELMA BAILEY | | | |
| 19a. INFORMANT'S NAME (Type/Print) KENNETH SINCLAIR LONESOME, SR. | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4334 ROBERTSON AVE. BALTIMORE, MD. 21206 | | | |
| 20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input checked="" type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) In state removal | | 20c. LOCATION — City or Town, State | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Ronald Wade, Dir.</i> | | | | 22. NAME AND ADDRESS OF FACILITY State Anatomy Board 655 W. Baltimore St., Baltimore, MD. 21201 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. FATTY LIVER Due to (OR AS A CONSEQUENCE OF): b. CHRONIC ALCOHOLISM Due to (OR AS A CONSEQUENCE OF): c. _____ Due to (OR AS A CONSEQUENCE OF): d. _____ Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | | Approximate Interval Between Onset and Death |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO | | | | | | | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER <i>Mario Prohio Jr</i> | | | | 29c. LICENSE NUMBER O.C.M.E | | 29d. DATE SIGNED (Month, Day, Year) JULY 3, 1995 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) MARIO PROHIO JR 111 Penn Street, Baltimore, Maryland 21201 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JUL 17 1995 | | | | 32. REGISTRAR'S SIGNATURE <i>Randall</i> | | | |

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|---|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) MOONEY, GEORGE George Mooney | | | | 2. DATE OF DEATH MONTH 7 DAY 12 YEAR 95 | | 3. TIME OF DEATH 14:47 PM | |
| 4. SOCIAL SECURITY NUMBER 217-68-4468 | | 5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 37 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) NOV 6, 1957 | |
| 8. BIRTHPLACE (State or Foreign Country) MD | | | | 9a. FACILITY NAME (If not institution, give street and number) Sinai Hospital | | 9b. CITY, TOWN OR LOCATION OF DEATH Baltimore | |
| 9c. COUNTY OF DEATH NA | | | | 10a. STATE MD | | 10b. COUNTY NA | |
| 10c. CITY, TOWN OR LOCATION Baltimore | | | | 10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | 10e. STREET AND NUMBER 3411 Calloway Ave | |
| 10f. ZIP CODE 21215 | | | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A | | 11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: Black | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12th grade College (1-4 or 5+) | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Truck Driver | | 16b. KIND OF BUSINESS/INDUSTRY Solid Waste | |
| 17. FATHER'S NAME (First, Middle, Last) George F. Mooney, Sr | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Hortense Freeman | | | |
| 19a. INFORMANT'S NAME (Type/Print) Hortense Mooney | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3411 Calloway Ave, Baltimore, MD 21215 | | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Woodlawn Cemetery 7/11/95 | | 20c. LOCATION — City or Town, State Baltimore, MD | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Bladys Wanner | | | | 22. NAME AND ADDRESS OF FACILITY Mark F.H. West 4300 Abubash Ave Balto, MD 21215 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → Pneumocystitis Pneumonia | | | | | | | |
| DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| b. Acquired Immunodeficiency Syndrome | | | | | | | |
| DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| c. | | | | | | | |
| DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| d. | | | | | | | |
| Approximate Interval Between Onset and Death 2 wks | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Kaposi Sarcoma | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO | | | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residences <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO | |
| 28d. DESCRIBE NOW INJURY OCCURRED | | | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | 29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER Robert Chow | | | | 29c. LICENSE NUMBER D34851 | | 29d. DATE SIGNED (Month, Day, Year) 7/12/95 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) #22, 1435 W. Belvedere Ave Balto MD 21215 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JUL 18 1995 | | | | 32. REGISTRAR'S SIGNATURE Julia Davidson-Randall | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

WRC

95-4032-005

ITEMS: 23 PART I, 27, 28a-f, PER MEO FILM G-726 8/10/95 t.t

95 21598

Item 7, Film 725, 7/18/95, lt

FOR
1 - STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

| | | | | | | | | | |
|---|--|---|--|---|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) ANDRE | | | | 2. DATE OF DEATH MONTH JULY DAY 12 YEAR 1995 | | | | 3. TIME OF DEATH 2:50 P. | |
| 4. SOCIAL SECURITY NUMBER 214-94-2375 | | 5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 16 YRS. | | 7. DATE OF BIRTH MONTH JULY DAY 6 YEAR 1979 | | 8. BIRTHPLACE (State or Foreign Country) MD | |
| 9a. FACILITY NAME (If not institution, give street and number) NORTHWEST HOSPITAL | | | | 9b. CITY, TOWN OR LOCATION OF DEATH RANDALLSTOWN | | | | 9c. COUNTY OF DEATH BALTIMORE | |
| 10a. STATE MD | | 10b. COUNTY BALTO | | 10c. CITY, TOWN OR LOCATION RANDALLSTOWN | | | | 10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 10e. STREET AND NUMBER 7316 A CASTLEMOOR RD | | | | 10f. ZIP CODE 21244 | | 10g. CITIZEN OF WHAT COUNTRY? U S A | | | |
| 11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No - If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE - American Indian, Black, White, etc. Specify: BLACK | | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 10TH | | College (1-4 or 5+) N/A | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) STUDENT | | 16b. KIND OF BUSINESS/INDUSTRY N/A | | | |
| 17. FATHER'S NAME (First, Middle, Last) ANDRE MOORE SR | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) VERRITTA GRAHAM | | | | | |
| 19a. INFORMANT'S NAME (Type/Print) VERRITA MCNEELY | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7316 A CASTLEMOOR RD BALTO MD 21244 | | | | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery or place of interment) GARRISON FOREST VET 7/17/95 | | 20c. LOCATION - City or Town, State OWINGS MILLS MD | | | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>John March</i> | | | | 22. NAME AND ADDRESS OF FACILITY MARCH F/H-WEST 4300 WABASH AVE | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. DROWNING DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST | | | | | | | | Approximate interval Between Onset and Death | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | |
| 27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input checked="" type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) FOUND: 7-12-95 | | 28b. TIME OF INJURY P M | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED SUBJECT DROWNED | |
| 28e. PLACE OF INJURY - At home, term, street, factory, office building, etc. (Specify) SWIMMING POOL | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) MILFORD MILL SWIM CLUB | | | | | |
| 29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. SIGNATURE AND TITLE OF CERTIFIER <i>Theodore M. King</i> | | 29c. LICENSE NUMBER O.C.M.E. | | 29d. DATE SIGNED (Month, Day, Year) JULY 13, 1995 | | | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>Theodore M. King</i> | | | | 111 Penn Street, Baltimore, Maryland 21201 | | | | | |
| 31. DATE FILED (Month, Day, Year) JUL 18 1995 | | 32. REGISTRAR'S SIGNATURE <i>John Randolph</i> | | | | | | | |

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|--|--|--|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) Frank J. McCarney | | | | 2. DATE OF DEATH MONTH July DAY 12 YEAR 1995 | | 3. TIME OF DEATH 2:50 p.m. | |
| 4. SOCIAL SECURITY NUMBER 218-26-9825 | | 5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 65 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) July 8 1930 | |
| 9a. FACILITY NAME (If not institution, give street and number) North Arundel Hospital | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Glen Burnie | | 9c. COUNTY OF DEATH Anne Arundel | |
| RESIDENCE OF DECEDENT | | | | | | | |
| 10a. STATE MARYLAND | | 10b. COUNTY ANNE ARUNDEL | | 10c. CITY, TOWN OR LOCATION SEVERNA PARK | | 10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 10a. STREET AND NUMBER 701 CYPRESS ROAD | | | | 10f. ZIP CODE 21146 | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: WHITE | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 10 College (1-4 or 5+) N/A | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) CONCRETE WORKER | | 16b. KIND OF BUSINESS/INDUSTRY CONSTRUCTION | | | |
| 17. FATHER'S NAME (First, Middle, Last) FRANK ZACKERY MCCARNEY | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) ALICE HUMMELL | | | |
| 19a. INFORMANT'S NAME (Type/Print) MARY E. BOHLEN | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 701 CYPRESS ROAD, SEVERNA PARK, MARYLAND 21146 | | | |
| 20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) HILLTOP SERVICE CORP. 7/13/95 | | 20c. LOCATION — City or Town, State TOWSON, MARYLAND | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>James J. Sibert</i> | | | | 22. NAME AND ADDRESS OF FACILITY SINGLETON FUNERAL HOME, 1 SECOND AVENUE, S.W. GLEN BURNIE, MARYLAND 21061 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Pneumonia DUE TO (OR AS A CONSEQUENCE OF): a. Congestive heart failure DUE TO (OR AS A CONSEQUENCE OF): b. Cerebrovascular accident DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Approximate interval between Onset and Death 1 month | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Coronary artery disease diabetes mellitus | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | |
| 27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28d. DESCRIBE HOW INJURY OCCURRED | | | |
| 28e. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | 29. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER <i>Angela</i> medical nurse officer | | | | 29c. LICENSE NUMBER D43977 | | 29d. DATE SIGNED (Month, Day, Year) July 12 1995 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) ANDRE ORETUNJI 301 Hospital Drive Glen Burnie Md 21061 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JUL 18 1995 | | | | 32. REGISTRAR'S SIGNATURE <i>John A. Anderson</i> | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 21600

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) James Mitchell | | | | 2. DATE OF DEATH MONTH 7 DAY 12 YEAR 95 | | 3. TIME OF DEATH 1:30 p.m. | |
| 4. SOCIAL SECURITY NUMBER 214-38-7100 | | 5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 56 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 4-29-39 | |
| 8a. FACILITY NAME (If not institution, give street and number) Inns of Evergreen, NW | | | | 8b. CITY, TOWN OR LOCATION OF DEATH Baltimore | | 8c. COUNTY OF DEATH BALTIMORE | |
| 10a. STATE Md | | 10b. COUNTY | | 10c. CITY, TOWN OR LOCATION Baltimore | | 10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | |
| 10e. STREET AND NUMBER 2525 W Belvedere Ave | | | | 10f. ZIP CODE 21215 | | 10g. CITIZEN OF WHAT COUNTRY? USA | |
| 11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: BLACK | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (8-12) | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) CLERK | | 16b. KIND OF BUSINESS/INDUSTRY MARTIN Supply INC | | | |
| 17. FATHER'S NAME (First, Middle, Last) James H. Mitchell | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) BRENNIE FALKNER | | | |
| 19a. INFORMANT'S NAME (Type/Print) BERNICE HAYNES | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6610 Vincent Lane Apt. 204 Balto Md 21215 | | | |
| 20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) ARBUTUS | | 20c. LOCATION — City or Town, State 7/18/95 BALTIMORE MD | | 20d. DATE | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Willie Howell Jr. | | | | 22. NAME AND ADDRESS OF FACILITY UNITY FUNERAL HOME 21201 108 W. NORTH AVE BALTO MD | | | |
| 23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → Metastatic Neuro Endocrine tumor | | | | | | | |
| Approximate interval between Onset and Death 2 months | | | | | | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Hypertension | | | | | | | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | | | 28e. PLACE OF INJURY — At home, term, street, factory, office building, etc. (Specify) | | | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | 28g. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER Allen Hettelman MD | | | | 29c. LICENSE NUMBER D21569 | | 29d. DATE SIGNED (Month, Day, Year) 7/13/95 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Allen Hettelman 1777 Reisterstown Rd #365 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JUL 18 1995 | | | | 32. REGISTRAR'S SIGNATURE | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 21601

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) OCTAVIA McDANIEL | | | | 2. DATE OF DEATH MONTH 7 DAY 16 YEAR 95 | | 3. TIME OF DEATH 10:30 AM | |
| 4. SOCIAL SECURITY NUMBER 088-12-9928 | | 5. SEX 1 <input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 68 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 11/26/26 | |
| 8. BIRTHPLACE (State or Foreign Country) VIRGINIA | | | | 9a. FACILITY NAME (If not institution, give street and number) Bon Secours Hosp. | | 9b. CITY, TOWN OR LOCATION OF DEATH Baltimore, Maryland | |
| 9c. COUNTY OF DEATH N/A | | | | 10a. STATE Virginia | | | |
| 10b. COUNTY Lynchburg | | | | 10c. CITY, TOWN OR LOCATION Lynchburg | | | |
| 10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | 10e. STREET AND NUMBER 1627 Early St. | | | |
| 10f. ZIP CODE 24503 | | | | 10g. CITIZEN OF WHAT COUNTRY? USA | | | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: Black | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Supervisor-Juvenile Home | | 16b. KIND OF BUSINESS/INDUSTRY City of Lynchburg | | | |
| 17. FATHER'S NAME (First, Middle, Last) Willie Brown | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Laura Logan | | | |
| 19a. INFORMANT'S NAME (Type/Print) Clinton McDaniel | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1627 Early St. Lynchburg, Virginia 24503 | | | |
| 20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Forest Hill Cemetery | | 20c. LOCATION (City or Town, State) Lynchburg, Virginia | | 20d. DATE 7/16/95 | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Kevin Parker | | | | 22. NAME AND ADDRESS OF FACILITY Nutter Funeral Homes, Inc. 2501 Gwynns Falls Pkwy. Balto., MD. 21216 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | | a. myocardial Infarction | | | | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | b. Hypertensive Cardiovascular Disease | | | | | |
| | | c. Chronic Renal failure | | | | | |
| | | d. | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| | | 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER Rosita R. Cruz M.D. | | | | 29c. LICENSE NUMBER Δ 30355 | | 29d. DATE SIGNED (Month, Day, Year) 7/16/95 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Rosita R. Cruz M.D. 2000 W. BALTIMORE ST. BALTIMORE Md | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JUL 18 1995 | | | | 32. REGISTRAR'S SIGNATURE John Andrew Randall | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 21602

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|--|--|---|--|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last) ANNA V. METZDORF | | | | 2. DATE OF DEATH MONTH DAY YEAR JULY 13, 1995 | | 3. TIME OF DEATH P. M. 4:18 | |
| 4. SOCIAL SECURITY NUMBER 212-74-2526 | | 5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 92 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) JULY 16, 1902 | |
| 9a. FACILITY NAME (If not institution, give street and number) 725 S. ELLWOOD AVE. | | | | 9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE | | 9c. COUNTY OF DEATH N/A | |
| RESIDENCE OF DECEDENT | | | | | | | |
| 10a. STATE MD. | | 10b. COUNTY N/A | | 10c. CITY, TOWN OR LOCATION BALTIMORE | | 10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 10e. STREET AND NUMBER 725 S. ELLWOOD AVE. | | | | 10f. ZIP CODE 21224 | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: WHITE | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 5 | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) HOMEMAKER | | 16b. KIND OF BUSINESS/INDUSTRY OWN HOME | | | |
| 17. FATHER'S NAME (First, Middle, Last) SAMUEL DEXTER | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) LILLIE PRICE | | | |
| 19a. INFORMANT'S NAME (Type/Print) DORIS KIESTER | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 725 S. ELLWOOD AVE. BALTO, MD. 21224 | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) OAKLAWN CEM. 7-17-95 | | 20c. LOCATION — City or Town, State BALTO. CO. MD. | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Thomas J. Skarda Jr.</i> | | | | 22. NAME AND ADDRESS OF FACILITY SKARDA FH. BALTO, MD. 21224 | | | |
| 23. PART I. Enter the disease(s) or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Cerebrovascular Accident DUE TO (OR AS A CONSEQUENCE OF): b. CHF DUE TO (OR AS A CONSEQUENCE OF): c. Asthma, Emphysema DUE TO (OR AS A CONSEQUENCE OF): d. Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | | Approximate Interval Between Onset and Death 1 day |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 6 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28d. DESCRIBE HOW INJURY OCCURRED | | | | | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | 28e. DESCRIBE HOW INJURY OCCURRED | | | | | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i> | | | | 29c. LICENSE NUMBER D17202 | | 29d. DATE SIGNED (Month, Day, Year) 7/15/95 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) S.S. DANG M.D. 101 St Helena Ave Balto Md 21222 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JUL 18 1995 | | | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95-4031-005

blh

ITEM: 7. PER F.H. FILM G-726 8/1/95 t.t

95 21603

ITEMS: 1. & 20b, PER F.H. FILM G-725 7/18/95 t.t

FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

| | | | | | | | |
|--|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) Beverly M MARION Millner | | | | 2. DATE OF DEATH MONTH DAY YEAR July 12 1995 | | 3. TIME OF DEATH 1450 M | |
| 4. SOCIAL SECURITY NUMBER 216-94-0946 | | 5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 58 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) FEB. 25, 1937 | |
| 9a. FACILITY NAME (If not institution, give street and number) Northwest Hospital Center | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Randallstown | | 9c. COUNTY OF DEATH Baltimore | |
| 10a. STATE MARYLAND | | 10b. COUNTY BALTIMORE | | 10c. CITY, TOWN OR LOCATION BALTIMORE | | 10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| 10e. STREET AND NUMBER 902 FLAGTREE COURT | | | | 10f. ZIP CODE 21208 | | 10g. CITIZEN OF WHAT COUNTRY? USA | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: WHITE | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 4 | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) CLERK | | 16b. KIND OF BUSINESS/INDUSTRY STATE OF MARYLAND | | | |
| 17. FATHER'S NAME (First, Middle, Last) LOUIS GREENBERG | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) IDA ALTER | | | |
| 19a. INFORMANT'S NAME (Type/Print) MR. HENRY MILLNER | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 902 FLAGTREE CT BALTIMORE, MD 21208 | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory, or other) BETH ISRAEL ROSES MONTEFIORE 7-14-1995 | | 20c. LOCATION — City or Town, State BALTIMORE, MD | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Ellenore Lewinson | | | | 22. NAME AND ADDRESS OF FACILITY SOL LEVINSON & BROS., INC. 6010 REISTERSTOWN ROAD BALTIMORE, MD 21215 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Hypertensive Arteriosclerotic Cardiovascular Disease DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Deep Vein Thrombosis | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| 29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER Theodore McHenry | | | | 29c. LICENSE NUMBER O.C.M.E. | | 29d. DATE SIGNED (Month, Day, Year) July 13 1995 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) THEODORE McHenry 111 Penn Street, Baltimore, Maryland 21201 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JUL 18 1995 | | | | 32. REGISTRAR'S SIGNATURE John Andrew Randall | | | |

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

6

95 21604

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | | | |
|--|--|--|---|--|--|---|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) Arlene E. McClure | | | | 2. DATE OF DEATH MONTH DAY YEAR JULY 15 1995 | | | | 3. TIME OF DEATH 10:30 A M | | | |
| 4. SOCIAL SECURITY NUMBER 005-01-4839 | | 5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | 6. AGE (In yrs. last birthday) 84 YRS. | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS. HOURS MIN. | | 7. DATE OF BIRTH (Month, Day, Year) JULY 26, 1910 | | 8. BIRTHPLACE (State or Foreign Country) Maine | |
| 9a. FACILITY NAME (If not institution, give street and number) Pleasant View Nursing Home | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Mt. Airy | | | | 9c. COUNTY OF DEATH Carroll | | | |
| RESIDENCE OF DECEDENT | | | | | | | | | | | |
| 10a. STATE Massachusetts | | 10b. COUNTY Essex | | 10c. CITY, TOWN OR LOCATION Georgetown | | | | 10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | |
| 10e. STREET AND NUMBER 6 Laurel Lane | | | | 10f. ZIP CODE 01830 | | | | 10g. CITIZEN OF WHAT COUNTRY? USA | | | |
| 11. MARITAL STATUS 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | | | 14. RACE — American Indian, Black, White, etc. Specify: White | | | |
| 16. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) "Unknown" College (1-4 or 5+) | | | | 18a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Hair Dresser | | | | 16b. KIND OF BUSINESS/INDUSTRY Beauty Shop | | | |
| 17. FATHER'S NAME (First, Middle, Last) Herbert McClure | | | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Ruth Ray | | | | | |
| 19a. INFORMANT'S NAME (Type/Print) Meredith J. Deshaies | | | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) Box 529 Livermore, Maine 04253 | | | | | |
| 20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Metro Crematory, Inc. 07/17/95 | | | | 20c. LOCATION — City or Town, State Baltimore, MD | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Dawn F. McDonald | | | | | | 22. NAME AND ADDRESS OF FACILITY Cremation Society of Maryland, Inc. 299 Frederick Rd. Baltimore, MD 21228 | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <u>cardiac arrhythmia</u> DUE TO (OR AS A CONSEQUENCE OF): b. <u>general atherosclerosis</u> DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Approximate Interval Between Onset and Death MIN YRS | | | | | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>Alzheimers</u> | | | | | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify) | | | | | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED | |
| 28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28i. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER Melvin Kordon | | | | | | 29c. LICENSE NUMBER D06589 | | 29d. DATE SIGNED (Month, Day, Year) July 15, 1995 | | | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Melvin Kordon, M.D. 4801 Dorsey Hall Dr. Ellicott City, MD 21042 | | | | | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JUL 18 1995 | | | | 32. REGISTRAR'S SIGNATURE John H. ... | | | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|--|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) ELLIS MILLER | | | | 2. DATE OF DEATH MONTH DAY YEAR JULY 14, 1995 | | 3. TIME OF DEATH 5:30 P M | |
| 4. SOCIAL SECURITY NUMBER 229-07-5934 | | 5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 79 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) JULY 5, 1916 | |
| 9a. FACILITY NAME (If not institution, give street and number) 1616 DENNIS AVE. | | | | 9b. CITY, TOWN OR LOCATION OF DEATH TOWSON | | 9c. COUNTY OF DEATH BALTIMORE | |
| 10a. STATE MARYLAND | | 10b. COUNTY BALTIMORE | | 10c. CITY, TOWN OR LOCATION TOWSON | | 10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 10e. STREET AND NUMBER 1616 DENNIS AVE. | | | | 10f. ZIP CODE 21204 | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES UNKNOWN | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: WHITE | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 5+ | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) SALES MANAGER | | 16b. KIND OF BUSINESS/INDUSTRY OTL | | | |
| 17. FATHER'S NAME (First, Middle, Last) ELLIS MILLER | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) HAZEL MEYER | | | |
| 19a. INFORMANT'S NAME (Type/Print) MRS. SUSAN SCHATOFF | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5698 MINERAL HILL RD., ELDERSBURG, MD. 21784 | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) BALTIMORE HERREW-BELAIR RD. 7/16/95 | | 20c. LOCATION — City or Town, State BALTIMORE, MD. | | 20d. DATE 7/16/95 | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i> | | | | 22. NAME AND ADDRESS OF FACILITY SOL LEVINSON & BROS., INC. 6010 REISTERSTOWN RD., BALTO., MD. 21215 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Ventricular Arrhythmia Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. Coronary Artery Disease b. Hypertensive Heart Disease c. Myocardial Infarction d. Stroke Approximate Interval Between Onset and Death minutes years years | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i> | | | | 29c. LICENSE NUMBER 176965 | | 29d. DATE SIGNED (Month, Day, Year) 7/15/95 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) B. A. Cochran, M.D., 846 W 36th St, Balto, Md 21211 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JUL 18 1995 | | | | 32. REGISTRAR'S SIGNATURE <i>[Signature]</i> | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 21606

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | | | | | | | |
|--|--|--|--|--|--|--|--|---|--|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) ROSE MAK | | | | 2. DATE OF DEATH MONTH JULY 11, DAY 1995 YEAR | | | | 3. TIME OF DEATH 1:50pm M | | | | | | | |
| 4. SOCIAL SECURITY NUMBER 214-74-0498 | | | | 5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 8. AGE (In yrs. last birthday) 91 YRS. | | IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. | | 7. DATE OF BIRTH MONTH JULY 25, DAY 1903 YEAR | | 8. BIRTHPLACE (State or Foreign Country) POLAND | | | |
| 9a. FACILITY NAME (If not institution, give street and number) MILFORD MANOR NURSING HOME | | | | | | 9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE | | | | 9c. COUNTY OF DEATH BALTIMORE | | | | | |
| RESIDENCE OF DECEDENT | | | | | | | | | | | | | | | |
| 10a. STATE MARYLAND | | | | 10b. COUNTY N/A | | | | 10c. CITY, TOWN OR LOCATION BALTIMORE | | | | 10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | |
| 10e. STREET AND NUMBER 7205 BROOKCREST WAY | | | | | | 10f. ZIP CODE 21208 | | | | 10g. CITIZEN OF WHAT COUNTRY? USA | | | | | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | | | 14. RACE — American Indian, Black, White, etc. Specify: WHITE | | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 10 College (1-4 or 5+) 10 | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) HOUSEWIFE | | | | 16b. KIND OF BUSINESS/INDUSTRY OWN HOME | | | | | | | |
| 17. FATHER'S NAME (First, Middle, Last) SHAYA | | | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) WALENKOWSKI SURA UNKNOWN | | | | | | | | | |
| 19a. INFORMANT'S NAME (Type/Print) MR. LEON MAK | | | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7205 BROOKCREST WAY BALTIMORE, MD 21208 | | | | | | | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) (ANSHE EMUNAH) AITZ CHAIM 7-13-1995 BALTIMORE, MD | | | | 20c. LOCATION — City or Town, State | | | | | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE ▶ <i>Glennice Levinson</i> | | | | | | 22. NAME AND ADDRESS OF FACILITY SOL LEVINSON & BROS., INC. 6010 REISTERSTOWN ROAD BALTIMORE, MD 21215 | | | | | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | | | | | | Approximate Interval Between Onset and Death | | | |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | | | | | | | | | | | | months | | | |
| a. <i>Chronic GI bleeding</i> | | | | | | | | | | | | months | | | |
| b. <i>Gastric Adenocarcinoma</i> | | | | | | | | | | | | months | | | |
| c. <i>Sequentially ill conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST</i> | | | | | | | | | | | | | | | |
| d. <i>Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.</i> | | | | | | | | | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Parkinson's Disease</i> | | | | | | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO N/A | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | | | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | | | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 28d. DESCRIBE NOW INJURY OCCURRED | | | | | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | 29b. SIGNATURE AND TITLE OF CERTIFIER <i>Dr. Paul Schwartz</i> | | | | 29c. LICENSE NUMBER D17118 | | 29d. DATE SIGNED (Month, Day, Year) ▶ 7/12/95 | | | | | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 4000 Old Court Rd Suite 203 Balt, Md 21208 | | | | | | | | | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JUL 18 1995 | | | | | | | | | | | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

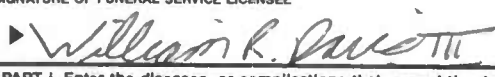
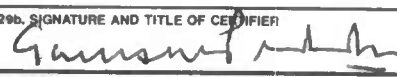
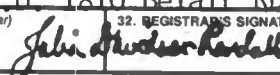
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 21607

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|---|--|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last) Calvin Miller SR. | | | | 2. DATE OF DEATH MONTH July DAY 16th YEAR 1995 | | 3. TIME OF DEATH 8.42AM | |
| 4. SOCIAL SECURITY NUMBER 235-20-9978 | | 5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 70 YRS. | | 7. DATE OF BIRTH MONTH July DAY 18th YEAR 24 | |
| 9a. FACILITY NAME (If not institution, give street and number) ER Fallston General Hospital | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Fallston | | 9c. COUNTY OF DEATH Harford | |
| RESIDENCE OF DECEDENT | | | | | | | |
| 10a. STATE Florida | | 10b. COUNTY SAINT LUCIE | | 10c. CITY, TOWN OR LOCATION Fort Pierce | | 10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 10e. STREET AND NUMBER 1719 Waldon Pond Drive | | | | 10f. ZIP CODE 34945 | | 10g. CITIZEN OF WHAT COUNTRY? USA | |
| 11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES WWII NAVY | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 12 | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) MARKET RESEARCHER | | 16b. KIND OF BUSINESS/INDUSTRY NEWSPAPER | | | |
| 17. FATHER'S NAME (First, Middle, Last) ROY MILLER | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) LENA BELL | | | |
| 19a. INFORMANT'S NAME (Type/Print) IRENE MILLER | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1719 WALDEN POND DR. FT. PIERCE, FLORIDA 34945 | | | |
| 20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) HAISLEY-HOBBS CREMATORY 7/95 FT. PIERCE FLA. | | 20c. LOCATION — City or Town, State | | 20d. DATE | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE  | | | | 22. NAME AND ADDRESS OF FACILITY HENRY W. JENKINS & SONS CO. 4905 YORK RD. BALTO., MD. 21212 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Acute Coronary Artery Disease DUE TO (OR AS A CONSEQUENCE OF): ASCVD b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | | Approximate Interval Between Onset and Death |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Hypertension | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | | | | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) NA | | 28b. TIME OF INJURY NA M | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED NA | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) NA | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) NA | | | |
| 29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER  DME | | | | 29c. LICENSE NUMBER D21809 | | 29d. DATE SIGNED (Month, Day, Year) 7-16-1995 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) G. S. Prabhu M.D. 1810 Belair RD # 102 Fallston Md. 21047 Tel No. 410-879-6564 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JUL 18 1995 | | | | 32. REGISTRAR'S SIGNATURE  | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 21608

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|---|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) Janet Mishler | | | | 2. DATE OF DEATH MONTH 7 DAY 9 YEAR 95 | | 3. TIME OF DEATH 8:45 P M | |
| 4. SOCIAL SECURITY NUMBER 220-18-7791 | | 5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 70 YRS. IF UNDER 1 YEAR: MONTHS _____ DAYS _____ IF UNDER 24 HRS.: HOURS _____ MIN. _____ | | 7. DATE OF BIRTH (Month, Day, Year) 5 17 25 | |
| 8a. FACILITY NAME (If not institution, give street and number) 102 Concord Drive | | | | 8b. CITY, TOWN OR LOCATION OF DEATH Perryville | | 8c. COUNTY OF DEATH Cecil | |
| 9a. STATE Maryland | | 9b. COUNTY Cecil | | 9c. CITY, TOWN OR LOCATION Perryville | | 9d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input type="checkbox"/> NO | |
| 10a. STREET AND NUMBER 102 Concord Drive | | | | 10b. ZIP CODE 21903 | | 10c. CITIZEN OF WHAT COUNTRY? | |
| 11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (9-12) _____ College (1-4 or 5+) _____ | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Bartender/Housewife | | 16b. KIND OF BUSINESS/INDUSTRY | | | |
| 17. FATHER'S NAME (First, Middle, Last) William Lewis | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) March Lewis | | | |
| 19a. INFORMANT'S NAME (Type/Print) Elmer Mishler | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 102 Concord Drive-Perryville, MD., 21903 | | | |
| 20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input checked="" type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) | | DATE | | 20c. LOCATION — City or Town, State | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Ronald Wade, Dir. | | | | 22. NAME AND ADDRESS OF FACILITY State Anatomy Board 655 W. Baltimore St., Baltimore, MD. 21201 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Small cell Ca Lung Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST COPD | | | | | | | Approximate Interval Between Onset and Death |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DCA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| | | 28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28e. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER Michael W. D. | | | | 29c. LICENSE NUMBER 023322 | | 29d. DATE SIGNED (Month, Day, Year) 7.9.95 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JUL 17 1995 | | 32. REGISTRAR'S SIGNATURE John Randall | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

REG. NO.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| 1. DECEDENT'S NAME (First, Middle, Last) | | | | 2. DATE OF DEATH | | | | 3. TIME OF DEATH | | | | | | | |
|--|--|---------|--|---|--|---------------------|--|--|--|-----------------------------------|--|--|--|---|--|
| Thelma E Meseke | | | | July 17 1995 | | | | 0805 AM | | | | | | | |
| 4. SOCIAL SECURITY NUMBER | | 5. SEX | | 6. AGE (In yrs. last birthday) | | 7. DATE OF BIRTH | | 8. BIRTHPLACE (State or Foreign Country) | | 9. COUNTY OF DEATH | | | | | |
| 212-42-8412 | | 1 M 2 F | | 87 YRS. | | 01/13/08 | | Maryland | | Anne Arundel | | | | | |
| 10a. STATE | | | | 10b. COUNTY | | | | 10c. CITY, TOWN OR LOCATION | | | | 10d. INSIDE CITY LIMITS? | | | |
| MARYLAND | | | | ANNE ARUNDEL | | | | GLEN BURNIE | | | | 1 YES 2 NO | | | |
| 11. MARITAL STATUS | | | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? | | | | 13. WAS DECEDENT OF HISPANIC ORIGIN? | | | | 14. RACE — American Indian, Black, White, etc. | | | |
| 1 NEVER MARRIED 2 MARRIED 3 WIDOWED 4 DIVORCED | | | | 1 YES 2 NO | | | | 1 YES 2 NO | | | | WHITE | | | |
| 15. DECEDENT'S EDUCATION | | | | 16a. DECEDENT'S USUAL OCCUPATION | | | | 16b. KIND OF BUSINESS/INDUSTRY | | | | | | | |
| Elementary/Secondary (0-12) College (1-4 or 5 +) | | | | SENIOR AID | | | | UNITED STATE GOVERNMENT | | | | | | | |
| 8 N/A | | | | | | | | | | | | | | | |
| 17. FATHER'S NAME (First, Middle, Last) | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) | | | | | | | | | | | |
| WESLEY B. TAYLOR | | | | BERTHA ELIZABETH STALLMAN | | | | | | | | | | | |
| 19a. INFORMANT'S NAME (Type/Print) | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) | | | | | | | | | | | |
| NANCY LEE GAVIN | | | | 301 BEACHSIDE DRIVE, STEVENSVILLE, MD. 21666 | | | | | | | | | | | |
| 20a. METHOD OF DISPOSITION | | | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) | | | | 20c. LOCATION — City or Town, State | | | | | | | |
| 1 BURIAL 2 CREMATION 3 REMOVAL FROM STATE 4 DONATION 5 OTHER (Specify) | | | | LOUDON PARK CEMETERY 7/20/1995 | | | | BALTIMORE, MARYLAND | | | | | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | | | | 22. NAME AND ADDRESS OF FACILITY | | | | | | | | | | | |
| [Signature] | | | | SINGLETON FUNERAL HOME, 1 SECOND AVENUE, S.W. GLEN BURNIE, MARYLAND 21061 | | | | | | | | | | | |
| 23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | | | | | | Approximate Interval Between Onset and Death | | | |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → BREAST CANCER | | | | | | | | | | | | | | | |
| DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | | | | | | | |
| Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST | | | | | | | | | | | | | | | |
| DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | | | | | | | |
| DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | | | | | | | |
| DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | | | | | | | | |
| SERVURE DISORDER HYPOCALCEMIA. | | | | | | | | | | | | | | | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN | | | | | | | | | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | | | | 26. PLACE OF DEATH (Check only one) | | | | | | | | 27a. WAS AN AUTOPSY PERFORMED? | | 27b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? | |
| 1 YES 2 NO | | | | HOSPITAL: 1 Inpatient 2 ER/Outpatient 3 DOA OTHER: 4 Nursing Home 5 Residence 6 Other (Specify) | | | | | | | | 1 YES 2 NO | | 1 YES 2 NO | |
| 27. MANNER OF DEATH | | | | 28a. DATE OF INJURY | | 28b. TIME OF INJURY | | 28c. INJURY AT WORK? | | 28d. DESCRIBE HOW INJURY OCCURRED | | | | | |
| 1 Natural 2 Accident 3 Suicide 4 Homicide 5 Pending Investigation 6 Could not be determined | | | | 28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | M 1 YES 2 NO | | | | | | | | | |
| | | | | | | | | 28t. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| 29a. CERTIFIER (Check only one) | | | | | | | | | | | | | | | |
| 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | | | | | | | |
| 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER | | | | 29c. LICENSE NUMBER | | | | 29d. DATE SIGNED (Month, Day, Year) | | | | | | | |
| [Signature] MEDICAL HOUSE OFFICER | | | | D43977 | | | | July 17 1995 | | | | | | | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) | | | | | | | | | | | | | | | |
| AJOKE ORETHUJI. NAH 301 HOSP DRIVE. GLEN BURNIE MS. 21061 | | | | | | | | | | | | | | | |
| 31. DATE FILED (Month, Day, Year) | | | | | | | | | | | | | | | |
| JUL 18 1995 | | | | | | | | | | | | | | | |

95 21610

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|---|--|--|---|
| 1. DECEDENT'S NAME (First, Middle, Last) JOSEPH STANISLAUS NEHRING | | | | 2. DATE OF DEATH MONTH JULY DAY 15 YEAR 1995 | | 3. TIME OF DEATH 5:35 P | |
| 4. SOCIAL SECURITY NUMBER 213.22.0556 | | 5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 69 YRS. | | 7. DATE OF BIRTH MONTH JULY DAY 6 YEAR 1926 | |
| 9a. FACILITY NAME (If not institution, give street and number) 26 FERNDAL AVENUE | | | | 9b. CITY, TOWN OR LOCATION OF DEATH GLEN BURNIE | | 9c. COUNTY OF DEATH ANNE ARUNDEL | |
| 10a. STATE MARYLAND | | | | 10b. COUNTY ANNE ARUNDEL | | 10c. CITY, TOWN OR LOCATION GLEN BURNIE | |
| 10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | | | 10e. STREET AND NUMBER 26 FERNDAL AVENUE | | | |
| 10f. ZIP CODE 21061 | | | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | | | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: WHITE | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 10 College (1-4 or 5+) NONE | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) MACHINIST | | 16b. KIND OF BUSINESS/INDUSTRY WESTINGHOUSE | | | |
| 17. FATHER'S NAME (First, Middle, Last) JOSEPH STANISLAUS NEHRING SR. | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) DOROTHY VICTORIA MAJKA | | | |
| 19a. INFORMANT'S NAME (Type/Print) DEANNA MARY NEHRING | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 26 FERNDAL AVE. GLEN BURNIE, MARYLAND 21061 | | | |
| 20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) HILLTOP SERVICE INC. 7-17 | | 20c. LOCATION — City or Town, State TOWSON, MARYLAND | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | | | | 22. NAME AND ADDRESS OF FACILITY SINGLETON FUNERAL HOME 1 SECOND AVE. S.W. GLEN BURNIE, MARYLAND | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Congestive Heart Failure s. DUE TO (OR AS A CONSEQUENCE OF): b. other severe cardiovascular disease DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. SEQUENTIALLY list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | | Approximate Interval Between Onset and Death 1 yr 5 yrs |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/> | | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. SIGNATURE AND TITLE OF CERTIFIER physician | | 29c. LICENSE NUMBER D29769 | | 29d. DATE SIGNED (Month, Day, Year) 7/17/95 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Marcelino D. Alvarez 516 W. Rolling Rd Baltimore | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JUL 18 1995 | | 32. REGISTRAR'S SIGNATURE | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filed in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 21611

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | | | | | |
|--|--|--|--|---|--|---|--|---|--|--|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) Lillian E. Nix | | | | 2. DATE OF DEATH MONTH July DAY 14, YEAR 1995 | | | | 3. TIME OF DEATH 11:30 P. M. | | | | | |
| 4. SOCIAL SECURITY NUMBER 215-01-1672 | | 5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 91 YRS. | | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS. HOURS MIN. | | 7. DATE OF BIRTH (Month, Day, Year) 2-2-1904 | | 8. BIRTHPLACE (State or Foreign Country) Maryland | |
| 9a. FACILITY NAME (If not institution, give street and number) Manor Care Towson Nursing Home | | | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Towson | | | | 9c. COUNTY OF DEATH Baltimore | | | |
| RESIDENCE OF DECEDENT | | | | | | | | | | | | | |
| 10a. STATE Maryland | | 10b. COUNTY Baltimore | | 10c. CITY, TOWN OR LOCATION Towson | | | | 10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | | |
| 10e. STREET AND NUMBER 509 E. Joppa Road | | | | | | 10f. ZIP CODE 21286 | | | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | | | |
| 11. MARITAL STATUS 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | | | 14. RACE — American Indian, Black, White, etc. Specify: White | | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 12 | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Homemaker | | | | 16b. KIND OF BUSINESS/INDUSTRY Own Home | | | | | |
| 17. FATHER'S NAME (First, Middle, Last) UNKNOWN Nix | | | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) UNKNOWN UNKNOWN | | | | | | | |
| 19a. INFORMANT'S NAME (Type/Print) Douglas W. Biser | | | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jefferson Bldg. Suite 300, 105 W. Chesapeake Ave. Towson, Md. | | | | | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Parkwood Cemetery 7-18-95 | | | | 20c. LOCATION — City or Town, State Parkville, Maryland | | | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Wallace S. Brooks, Jr. | | | | | | 22. NAME AND ADDRESS OF FACILITY Ruck Towson Funeral Home, Inc. 1050 York Road, Towson, Md. 21204 | | | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. CHRONIC LYMPHOBLASTIC LEUKEMIA DUE TO (OR AS A CONSEQUENCE OF): b. ATHEROSCLEROTIC CARDIOVASCULAR DISEASE DUE TO (OR AS A CONSEQUENCE OF): c. DEMENTIA DUE TO (OR AS A CONSEQUENCE OF): d. Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST | | | | | | | | | | | | Approximate Interval Between Onset and Death | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | | | | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/> | | | | | | | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED | | | |
| 28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER D.S. G... M.D. | | | | | | 29c. LICENSE NUMBER D29770 | | | | 29d. DATE SIGNED (Month, Day, Year) 7/17/95 | | | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Sergio A. Cassanego, M.D. 8813 Waltham Woods Road, Baltimore, Maryland | | | | | | | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JUL 18 1995 | | | | | | | | | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 21612

ITEM: 10e, PER F.H. FILM G-725 7/18/95 t.t

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | |
|--|--|---|--|---|--|--|---|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) FREDA | | | | 2. DATE OF DEATH MONTH JULY DAY 12 , YEAR 1995 | | | | 3. TIME OF DEATH 5:40 P. | |
| 4. SOCIAL SECURITY NUMBER 061-07-8999 | | 5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (in yrs. last birthday) 88 | | 7. DATE OF BIRTH (Month, Day, Year) JAN. 30, 1907 | | 8. BIRTHPLACE (State or Foreign Country) MARYLAND | |
| 9a. FACILITY NAME (If not institution, give street and number) CHERRYWOOD MANOR NURSING HOME | | | | 9b. CITY, TOWN OR LOCATION OF DEATH REISTERSTOWN | | | | 9c. COUNTY OF DEATH BALTIMORE | |
| RESIDENCE OF DECEDENT | | | | | | | | | |
| 10a. STATE MARYLAND | | 10b. COUNTY CARROLL | | 10c. CITY, TOWN OR LOCATION FINKSBURG | | | | 10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 10e. STREET AND NUMBER 2303 OLD WESTMINSTER PLACE PIKE | | | | 10f. ZIP CODE 21048 | | 10g. CITIZEN OF WHAT COUNTRY? USA | | | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | | 14. RACE — American Indian, Black, White, etc. Specify: WHITE | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) HOUSEWIFE | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) HOUSEWIFE | | | 16b. KIND OF BUSINESS/INDUSTRY OWN HOME | | |
| 17. FATHER'S NAME (First, Middle, Last) BENJAMIN BASS | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) JENNIE ROSENBERG | | | | | |
| 19a. INFORMANT'S NAME (Type/Print) MRS. JANET GALYON | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2303 OLD WESTMINSTER PIKE FINKSBURG, MD 21048 | | | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) BNAI ISRAEL | | DATE 7-14-1995 | | 20c. LOCATION — City or Town, State BALTIMORE, MD | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i> | | | | 22. NAME AND ADDRESS OF FACILITY SOL LEVINSON & BROS., INC. 6010 REISTERSTOWN RD. BALTO., MD 21215 | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <i>Acute Respiratory Failure</i> DUE TO (OR AS A CONSEQUENCE OF): Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. <i>Chronic Heart Failure + Renal Effusion</i> DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Approximate interval Between Onset and Death | | | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/> | | | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED | |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER <i>Herman Brecher M.D.</i> | | | | 29c. LICENSE NUMBER DO 1317 | | 29d. DATE SIGNED (Month, Day, Year) 7/13/95 | | | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Herman Brecher, M.D. 6410 Windsor Mill Rd. Balto MD 21207 | | | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JUL 18 1995 | | 32. REGISTRAR'S SIGNATURE <i>[Signature]</i> | | | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 21613

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) <i>Esther Oursler</i> | | | | 2. DATE OF DEATH MONTH <i>7</i> DAY <i>15</i> YEAR <i>1995</i> | | 3. TIME OF DEATH <i>5:15 A</i> M | |
| 4. SOCIAL SECURITY NUMBER <i>215-44-1423</i> | | 5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) <i>86</i> YRS. | | 7. DATE OF BIRTH (Month, Day, Year) <i>Feb. 27, 1909</i> | |
| 8a. FACILITY NAME (If not institution, give street and number) <i>Chapel Hill Nursing Home</i> | | | | 8b. CITY, TOWN OR LOCATION OF DEATH <i>Randallstown</i> | | 8c. COUNTY OF DEATH <i>Baltimore</i> | |
| 9a. RESIDENCE OF DECEDENT | | | | 9b. CITY, TOWN OR LOCATION OF DEATH | | | |
| 10a. STATE <i>Maryland</i> | | 10b. COUNTY <i>Carroll</i> | | 10c. CITY, TOWN OR LOCATION <i>Hampstead</i> | | 10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| 10e. STREET AND NUMBER <i>1211 Wynside Lane</i> | | | | 10f. ZIP CODE <i>21074</i> | | 10g. CITIZEN OF WHAT COUNTRY? <i>United States</i> | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: <i>White</i> | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <i>12th grade H.S.</i> College (1-4 or 5+) <i>Ret: U.S. Post Office</i> | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <i>Clerk</i> | | 16b. KIND OF BUSINESS/INDUSTRY | |
| 17. FATHER'S NAME (First, Middle, Last) <i>George W. Berry</i> | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) <i>Edna Dell</i> | | | |
| 19a. INFORMANT'S NAME (Type/Print) <i>Mr. L. Gerald Oursler</i> | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>1211 Wynside Lane Hampstead, MD 21074</i> | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) <i>Wards Chapel U.M. Ch Cemetery 7/18 Randallstown, MD</i> | | 20c. LOCATION — City or Town, State | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>James B. Covey</i> | | | | 22. NAME AND ADDRESS OF FACILITY <i>Loring Byers Funeral Directors, Inc. 8728 Liberty Road Randallstown, MD 21133</i> | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Alzheimer's Dementia</i> DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. | | | | | | | Approximate Interval Between Onset and Death |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |
| 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | | |
| 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED | |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER <i>Allen J. Chingus, M.D.</i> | | | | 29c. LICENSE NUMBER <i>029085</i> | | 29d. DATE SIGNED (Month, Day, Year) <i>7/15/95</i> | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>Allen J. Chingus, M.D. 5310 Old Court RD 21133</i> | | | | | | | |
| 31. DATE FILED (Month, Day, Year) <i>JUL 1 8 1995</i> | | | | 32. REGISTRAR'S SIGNATURE <i>John A. ...</i> | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. In by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR
STATE
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
 CERTIFICATE OF DEATH REG. NO.

REG NO

BALTIMORE. MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

| | | | | |
|---|--|--|--|---|
| 1. DECEDENT'S NAME (First, Middle, Last) Lena R. Orla | | 2. DATE OF DEATH MONTH 07 DAY 12 YEAR 95 | | 3. TIME OF DEATH 7:15 PM |
| 4. SOCIAL SECURITY NUMBER 217-03-8349 | 5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F | 6. AGE (In yrs. last birthday) 88 YRS. | IF UNDER 1 YEAR MONTHS 0 DAYS 0 | IF UNDER 24 HRS. HOURS 0 MIN. 0 |
| 7. DATE OF BIRTH (Month, Day, Year) Dec. 12, 1906 | | 8. BIRTHPLACE (State or Foreign Country) Maryland | | |
| 9a. FACILITY NAME (If not institution, give street and number) Belforest Nursing Home & Rehab. Ctr. | | 9b. CITY, TOWN OR LOCATION OF DEATH Forest Hill, Md | | 9c. COUNTY OF DEATH Harford |
| 10a. STATE Maryland | | 10b. COUNTY N/A | | 10c. CITY, TOWN OR LOCATION Baltimore City |
| 10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | 10e. STREET AND NUMBER 243 Albemarle St. | | |
| 10f. ZIP CODE 21202 | | 10g. CITIZEN OF WHAT COUNTRY? USA | | |
| 11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |
| 14. RACE — American Indian, Black, White, etc. Specify: White | | 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 yrs. College (1-4 or 5+) N/A | | |
| 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Seamstress | | 16b. KIND OF BUSINESS/INDUSTRY Clothing Workers of America | | |
| 17. FATHER'S NAME (First, Middle, Last) Luca Granese | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Antionette DiNenna | | |
| 19a. INFORMANT'S NAME (Type/Print) Frank L. Orla | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2602 Parallel Path Abington, Md. 21009 | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Gardens of Faith Cem. 7-17-95 | | 20c. LOCATION — City or Town, State Baltimore, Maryland |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Wm. G. Cook | | 22. NAME AND ADDRESS OF FACILITY Lassahn Funeral Home 7401 Belair Rd. Baltimore, Md. 21236 | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → ASCD Sequitentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST { Pneumonia, terminal Diabetes mellitus | | | | Approximate interval Between Onset and Death years 1 week years |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | |
| 27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |
| 28d. DESCRIBE NOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | |
| 29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER PERFECTO C. VALARAO M.D. | | 29c. LICENSE NUMBER D16389 | | 29d. DATE SIGNED (Month, Day, Year) 7/13/95 |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (Item 27) (Type, Print) PERFECTO C. VALARAO, M.D., 1716 Harford Rd Fallston, MD 21047 | | | | |
| 31. DATE FILED (Month, Day, Year) JUL 18 1995 | | 32. REGISTRAR'S SIGNATURE Johanna Davidson | | |

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|---|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) William C. Price Sr. | | | | 2. DATE OF DEATH MONTH DAY YEAR July 15, 1995 | | 3. TIME OF DEATH 3 A M | |
| 4. SOCIAL SECURITY NUMBER 230-28-5475 | | 5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 66 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) Mar. 29, 1929 | |
| 8. BIRTHPLACE (State or Foreign Country) Virginia | | | | 9a. FACILITY NAME (If not institution, give street and number) 359 Baltimore Avenue | | 9b. CITY, TOWN OR LOCATION OF DEATH Odenton | |
| 9c. COUNTY OF DEATH Anne Arundel | | | | 10a. STATE MD | | 10b. COUNTY Anne Arundel | |
| 10c. CITY, TOWN OR LOCATION Odenton | | | | 10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 10e. CITIZEN OF WHAT COUNTRY? USA | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES 1946-66 | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | |
| 14. RACE — American Indian, Black, White, etc. Specify: White | | | | 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (14 or 5+) 12 | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Sargeant First Class | |
| 16b. KIND OF BUSINESS/INDUSTRY U.S. Army | | | | 17. FATHER'S NAME (First, Middle, Last) Holbert Price | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Pearl DeBord | |
| 19a. INFORMANT'S NAME (Type/Print) Lola G. Price | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 359 Baltimore Avenue, Odenton, MD 21113 | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Arlington National Cem. 7/20 | | 20c. LOCATION — City or Town, State Arlington, VA | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSER <i>Balank J. Carroll</i> | | | | 22. NAME AND ADDRESS OF FACILITY Hardesty Funeral Home, P.A. 12 Ridgely Ave., Annapolis, MD 21401 | | | |
| 23. PART I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Liver failure from metastatic lung cancer DUE TO (OR AS A CONSEQUENCE OF): b. Small cell lung cancer with liver metastases DUE TO (OR AS A CONSEQUENCE OF): c. Brain metastases from small cell lung cancer DUE TO (OR AS A CONSEQUENCE OF): d. Chronic lung disease Approximate interval Between Onset and Death 1 mo 1 yr 3 mo 10 yrs | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Arthritis | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/> | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER <i>Linda M. Burrell MD</i> | | | | 29c. LICENSE NUMBER D35996 | | 29d. DATE SIGNED (Month, Day, Year) 7-18-95 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) LINDA M BURRELL MD WIRAMC WASHINGTON DC 20307 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JUL 18 1995 | | | | 32. REGISTRAR'S SIGNATURE <i>John Andrew Randall</i> | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|---|--|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last) ORA BELLE PETTIE | | | | 2. DATE OF DEATH MONTH DAY YEAR JULY 11 1995 | | 3. TIME OF DEATH 11:55 P M | |
| 4. SOCIAL SECURITY NUMBER 226-10-9820 | | 5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 86 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 7 1 09 | |
| 9a. FACILITY NAME (If not institution, give street and number) GREATER BALTIMORE MEDICAL CENTER | | | | 9b. CITY, TOWN OR LOCATION OF DEATH TOWSON | | 9c. COUNTY OF DEATH BALTIMORE | |
| RESIDENCE OF DECEDENT | | | | | | | |
| 10a. STATE Maryland | | 10b. COUNTY Baltimore | | 10c. CITY, TOWN OR LOCATION Baltimore | | 10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 10e. STREET AND NUMBER 2027 N. Payson Street | | | | 10f. ZIP CODE 21217 | | 10g. CITIZEN OF WHAT COUNTRY? USA | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: Black | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 8+) 5th | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Pressure Presser | | 16b. KIND OF BUSINESS/INDUSTRY Unknown | | | |
| 17. FATHER'S NAME (First, Middle, Last) George Edwards | | | | 16. MOTHER'S NAME (First, Middle, Maiden Surname) Lillie | | | |
| 19a. INFORMANT'S NAME (Type/Print) James R. K. Pettie | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3527 JoAnne Drive | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Arbutus Memorial Park 7/15/95 | | 20c. LOCATION — City or Town, State Balto. Maryland | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Joseph R. Walter Jr.</i> | | | | 22. NAME AND ADDRESS OF FACILITY Unity Funeral Home 108 W. North Avenue | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. CONGESTIVE HEART FAILURE DUE TO (OR AS A CONSEQUENCE OF): b. ACUTE MYOCARDIAL INFARCTION DUE TO (OR AS A CONSEQUENCE OF): c. GASTROINTESTINAL BLEEDING DUE TO (OR AS A CONSEQUENCE OF): d. | | | | | | | Approximate Interval Between Onset and Death |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. INTESTINAL OBSTRUCTION | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/> | | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 6 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 28e. PLACE OF INJURY — At home, term, street, factory, office building, etc. (Specify) | | | | 28d. DESCRIBE HOW INJURY OCCURRED | | | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. SIGNATURE AND TITLE OF CERTIFIER <i>Marcelo M. Menendez MD</i> | | 29c. LICENSE NUMBER D07697 | | 29d. DATE SIGNED (Month, Day, Year) 07/12/95 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) MARCELO M. MENENDEZ M.D. 7505 OSLER DR #408 TOWSON, MD 21204 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JUL 18 1995 | | 32. REGISTRAR'S SIGNATURE <i>John A. Anderson-Randall</i> | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 21617

1 - FOR
STATE
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | |
|--|--|---|--|--|---|---|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) Eric Jude Perkins | | | | 2. DATE OF DEATH MONTH DAY YEAR JULY 13 95 | | 3. TIME OF DEATH 9:22 A.M. | | |
| 4. SOCIAL SECURITY NUMBER N/A | | 5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | 6. AGE (In yrs. last birthday) YRS. 12 9 | | 7. DATE OF BIRTH (Month, Day, Year) July 12, 95 | | 8. BIRTHPLACE (State or Foreign Country) Maryland | |
| 9a. FACILITY NAME (If not institution, give street and number) Union Memorial Hospital | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Baltimore City | | 9c. COUNTY OF DEATH Baltimore City | | |
| RESIDENCE OF DECEDENT | | | | | | | | |
| 10a. STATE Maryland | | 10b. COUNTY Baltimore | | 10c. CITY, TOWN OR LOCATION Randallstown | | 10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | |
| 10e. STREET AND NUMBER 22 Coachman Court Apt. 102 | | | | 10f. ZIP CODE 21133 | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | | |
| 11. MARITAL STATUS 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: Black | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) None | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Child | | 16b. KIND OF BUSINESS/INDUSTRY N/A | | |
| 17. FATHER'S NAME (First, Middle, Last) Zachary Anister | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Erica Perkins | | | | |
| 19a. INFORMANT'S NAME (Type/Print) Mrs. Erica Perkins | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 22 Coachman Court Apt. 102 Randallstown, MD 21133 | | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Lake View Mem. Park 7/18 | | 20c. LOCATION — City or Town, State Sykesville, Maryland | | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Stephan M Jenkins</i> | | | | 22. NAME AND ADDRESS OF FACILITY Loring Byers Funeral Directors, Inc. 8728 Liberty Road Randallstown, MD 21133 | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. SEPSIS DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST { b. PREMATURITY DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Approximate Interval Between Onset and Death 3 HOURS 12 HRS | | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | |
| 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER <i>Asay K. Verma, MD. (NEONATOLOGIST)</i> | | | | 29c. LICENSE NUMBER D37615 | | 29d. DATE SIGNED (Month, Day, Year) 7-13-95 | | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) ASAY K. VERMA, MD UNION MEMORIAL HOSPITAL, BALTIMORE, MD 21218. | | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JUL 18 1995 | | | | 32. REGISTRAR'S SIGNATURE <i>John A. Anderson</i> | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | | |
|--|--|---|--|---|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) WARREN JACK RASH | | | | 2. DATE OF DEATH MONTH DAY YEAR JULY 14, 1995 | | 3. TIME OF DEATH 18:47 P M | | | | |
| 4. SOCIAL SECURITY NUMBER 219-60-7962 | | 5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 40 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) AUG 27, 1954 | | 8. BIRTHPLACE (State or Foreign Country) Maryland | | |
| 9a. FACILITY NAME (If not Institution, give street and number) 3129 DILLON ST. | | | | 9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE | | | 9c. COUNTY OF DEATH N/A | | | |
| 10a. STATE Maryland | | 10b. COUNTY N/A | | 10c. CITY, TOWN OR LOCATION Baltimore | | | 10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | |
| 10e. STREET AND NUMBER 3129 Dillon Street | | | | 10f. ZIP CODE 21224 | | 10g. CITIZEN OF WHAT COUNTRY? USA | | | | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White | | | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 12 | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Carpenter/Maintenance | | 16b. KIND OF BUSINESS/INDUSTRY Apartment Complex | | | | | | |
| 17. FATHER'S NAME (First, Middle, Last) Warren Onsby Rash | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Ethel Louise Hodge | | | | | | |
| 19a. INFORMANT'S NAME (Type/Print) Pamdoria J. Goldrick | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8254 Kavanagh Rd. Baltimore, MD 21222 | | | | | | |
| 20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of facility, crematory or other place) Metro Crematory, Inc. 07/17/95 | | 20c. LOCATION — City or Town, State Baltimore, MD | | | | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Dawn F. McDonald Dawn F. McDonald | | | | 22. NAME AND ADDRESS OF FACILITY Cremation Society of Maryland, Inc. 299 Frederick Rd. Baltimore, MD 21228 | | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <u>HANGING</u> DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. | | | | | | | Approximate Interval Between Onset and Death | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/> | | | | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | | |
| 27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input checked="" type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) 7/14/95 | | 28b. TIME OF INJURY 1830 P M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED SUBJECT HANGED SELF | | |
| | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) HOME | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) 3129 DILLON ST. BALTIMORE MD | | | | |
| 29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. SIGNATURE AND TITLE OF CERTIFIER [Signature] MARIO F. GOLUE JR. MD | | | | 29c. LICENSE NUMBER OCME | | 29d. DATE SIGNED (Month, Day, Year) JULY 15, 1995 | | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) MARIO F. GOLUE JR. MD 111 Penn Street, Baltimore, Maryland 21201 | | | | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JUL 18 1995 | | 32. REGISTRAR'S SIGNATURE [Signature] | | | | | | | | |

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

3

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) CHARLES EDWARD RICHARDSON, SR. | | | | 2. DATE OF DEATH MONTH 7 DAY 13 YEAR 95 | | 3. TIME OF DEATH 3:11 P.M. | |
| 4. SOCIAL SECURITY NUMBER 213-09-4179 | | 5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 79 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) April 28, 1916 | |
| 9a. FACILITY NAME (If not institution, give street and number) Johns Hopkins Bayview Medical Ctr. | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Baltimore City | | 9c. COUNTY OF DEATH N/A | |
| RESIDENCE OF DECEDENT | | | | | | | |
| 10a. STATE Maryland | | 10b. COUNTY Baltimore | | 10c. CITY, TOWN OR LOCATION Dundalk | | 10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 10e. STREET AND NUMBER 1618 Lynch Road | | | | 10f. ZIP CODE 21222 | | 10g. CITIZEN OF WHAT COUNTRY? United States | |
| 11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 Years College (1-4 or 5+) | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Policeman | | 16b. KIND OF BUSINESS/INDUSTRY Baltimore County | |
| 17. FATHER'S NAME (First, Middle, Last) Charles E. Richardson | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Edna May Whitney | | | |
| 19a. INFORMANT'S NAME (Type/Print) Charles E. Richardson, Jr. | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 225 Pritchard Road Virginia Beach, Virginia 23452 | | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Oak Lawn Cemetery 7/17/95 | | 20c. LOCATION — City or Town, State Baltimore, MD | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | | | | 22. NAME AND ADDRESS OF FACILITY Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, MD 21222 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | | a. PULMONARY FAILURE | | | | | |
| | | b. SEVERE C.O.P.D. | | | | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | c. | | | | | |
| | | d. | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO | |
| 27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO | |
| | | 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER C. T. MORROW MD | | | | 29c. LICENSE NUMBER D25203 | | 29d. DATE SIGNED (Month, Day, Year) 7/13/95 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) C. T. MORROW MD, JOHNS HOPKINS BAYVIEW MED CTR. | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JUL 18 1995 | | | | REGISTERAR'S SIGNATURE BALTIMORE, MD. | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.


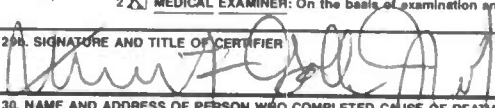

95-4134-005

95 21620

blh

1 -
FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|--|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) Monchel Irvette Sheppard | | | | 2. DATE OF DEATH MONTH DAY YEAR July 15 1995 | | 3. TIME OF DEATH 1355 M | |
| 4. SOCIAL SECURITY NUMBER 213-11-4292 | | 5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 9 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) NOV. 26, 1985 | |
| 8. BIRTHPLACE (State or Foreign Country) BALTIMORE, MD | | | | 9a. FACILITY NAME (If not institution, give street and number) Franklin Square Hospital | | 9b. CITY, TOWN OR LOCATION OF DEATH Rossville | |
| 9c. COUNTY OF DEATH Baltimore | | | | 10a. STATE MARYLAND | | 10b. COUNTY n/a | |
| 10c. CITY, TOWN OR LOCATION BALTIMORE | | | | 10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | 10e. STREET AND NUMBER 845 HILLMAN COURT | |
| 10f. ZIP CODE 21202 | | | | 10g. CITIZEN OF WHAT COUNTRY? UNITED STATES | | 11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: BLACK | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 4 th College (1-4 or 5+) - | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) STUDENT | | 16b. KIND OF BUSINESS/INDUSTRY ELEMENTARY SCHOOL | |
| 17. FATHER'S NAME (First, Middle, Last) WILLIAM MONROE | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) MARGARET T. SHEPHERD | | | |
| 19a. INFORMANT'S NAME (Type/Print) MARGARET T. SHEPHERD | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 845 HILLMAN COURT, BALTIMORE, MD 21202 | | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) GARRISON FOREST VA CEM. 7-21 | | 20c. LOCATION — City or Town, State OWINGS MILLS, MD | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE  | | | | 22. NAME AND ADDRESS OF FACILITY WM. C. MARCH FH.-1101 E. NORTH AVENUE | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → PROWNING a. DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | |
| 27. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | | | 28a. DATE OF INJURY (Month, Day, Year) 7/15/95 | | 28b. TIME OF INJURY M | |
| 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | 28d. DESCRIBE HOW INJURY OCCURRED SUBJECT PROWNING | | | |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) SWIMMING POOL | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) 1503 CHAPEL HILL RD, ROSETT, MD | | | |
| 29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER  | | | | 29c. LICENSE NUMBER O.C.M.E. | | 29d. DATE SIGNED (Month, Day, Year) July 16 1995 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) MARIO F. GOLUB JR. MD 111 Penn Street, Baltimore, Maryland 21201 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JUL 18 1995 | | | | 32. REGISTRAR'S SIGNATURE  | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

BALTIMORE, MARYLAND 21215-0020

BALTIMORE, MARYLAND 21215-0020

BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 21621

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|---|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) HELENA ALVINA SHUGARS | | | | 2. DATE OF DEATH MONTH JULY DAY 13 YEAR 1995 | | 3. TIME OF DEATH 11:00 P | |
| 4. SOCIAL SECURITY NUMBER 215-01-4517 | | 5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 83 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 05-16-1912 | |
| 8. BIRTHPLACE (State or Foreign Country) MARYLAND | | | | 9. CITY, TOWN OR LOCATION OF DEATH BALTIMORE | | 10. COUNTY OF DEATH N/A | |
| 11. FACILITY NAME (If not institution, give street and number) 1944 SPONSON STREET | | | | 12. CITY, TOWN OR LOCATION BALTIMORE | | 13. COUNTY OF DEATH N/A | |
| 14a. STATE MARYLAND | | 14b. COUNTY N/A | | 14c. CITY, TOWN OR LOCATION BALTIMORE | | 14d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | |
| 15a. STREET AND NUMBER 1944 SPONSON STREET | | | | 15b. ZIP CODE 21230 | | 15c. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 16. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced | | 17. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 18. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 19. RACE — American Indian, Black, White, etc. Specify: WHITE | |
| 20. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (9-12) UNKNOWN College (1-4 or 5+) UNKNOWN | | 21. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) SEAMRESS | | 22. KIND OF BUSINESS/INDUSTRY TAYLOR | | | |
| 23. FATHER'S NAME (First, Middle, Last) MARTIN NATKUS | | | | 24. MOTHER'S NAME (First, Middle, Maiden Surname) MARY STRAUSS | | | |
| 25. INFORMANT'S NAME (Type/Print) ELSIE GARRETT | | 26. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1944 SPONSON STREET, BALTIMORE, MD. 21230 | | | | | |
| 27. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 28. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) GLEN HAVEN MEMORIAL PARK 7/17/95 | | 29. LOCATION — City or Town, State GLEN BURNIE, MD. | | | |
| 30. SIGNATURE OF FUNERAL SERVICE LICENSEE | | | | 31. NAME AND ADDRESS OF FACILITY SINGLETON FUNERAL HOME, 1 SECOND AVENUE, S.W. GLEN BURNIE, MARYLAND 21061 | | | |
| 23. PART I. Enter the disease(s) or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → STROKE Due to (or as a consequence of): a. HYPERTENSION Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST. | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ISCHEMIC HEART DISEASE DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/> | | | | | | | |
| 32. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 33. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 34. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide | | 35a. DATE OF INJURY (Month, Day, Year) | | 35b. TIME OF INJURY M | | 35c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 36. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 37. DESCRIBE HOW INJURY OCCURRED | | | | | |
| 38. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | 39. CERTIFIER 29a. CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Herbert A. Kushner MD 29b. MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> | | | | | |
| 30. SIGNATURE AND TITLE OF CERTIFIER Herbert A. Kushner MD | | 31. LICENSE NUMBER 105551 | | 32. DATE SIGNED (Month, Day, Year) 7/14/95 | | | |
| 33. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Herbert Kushner MD 419 W. Redwood St Balto. MD 21201 | | | | | | | |
| 34. DATE FILED (Month, Day, Year) JUL 18 1995 | | 35. REGISTRAR'S SIGNATURE | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

P.O. BOX 68760

10

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 5 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 21622

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|---|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) CHARLES BENJAMIN SIMONDS | | | | 2. DATE OF DEATH MONTH DAY YEAR JULY 10, 1995 | | 3. TIME OF DEATH 5:27 PM | |
| 4. SOCIAL SECURITY NUMBER 215-03-5727 | | 5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 86 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 08-20-1908 | |
| 9a. FACILITY NAME (If not institution, give street and number) 123 MAIN AVENUE, S.E. | | | | 9b. CITY, TOWN OR LOCATION OF DEATH GLEN BURNIE | | 9c. COUNTY OF DEATH ANNE ARUNDEL | |
| RESIDENCE OF DECEDENT | | | | | | | |
| 10a. STATE MARYLAND | | 10b. COUNTY ANNE ARUNDEL | | 10c. CITY, TOWN OR LOCATION GLEN BURNIE | | 10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 10e. STREET AND NUMBER 123 MAIN AVENUE, S.E. | | | | 10f. ZIP CODE 21061 | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: WHITE | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 6 College (1-4 or 5+) NONE | | 15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) FOREMAN | | 15b. KIND OF BUSINESS/INDUSTRY LINEN THREAD COMPANY | | | |
| 17. FATHER'S NAME (First, Middle, Last) CHARLES B. SIMONDS | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) MOLLY SMITH | | | |
| 19a. INFORMANT'S NAME (Type/Print) MARIE SIMONDS | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 123 MAIN AVENUE, S.E., GLEN BURNIE, MD. 21061 | | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) HOLY CROSS CEMETERY | | 20c. LOCATION — City or Town, State BROOKLYN PARK, MD. | | 20d. DATE 7/14/1995 | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | | | | 22. NAME AND ADDRESS OF FACILITY SINGLETON FUNERAL HOME, 1 SECOND AVENUE, S.W., GLEN BURNIE, MD. 21061 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Coronary Heart Failure Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST due to Hypertensive Heart Disease DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): Approximate Interval Between Onset and Death hours years | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Arteriosclerosis | | | | | | 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28d. DESCRIBE HOW INJURY OCCURRED | | | |
| 29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. SIGNATURE AND TYPE OF CERTIFIER | | 29c. LICENSE NUMBER 202583 | | 29d. DATE SIGNED (Month, Day, Year) 7/14/95 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) A.E. SUBONG, JR., M.D., 206 CRAIN HIGHWAY, S.W., GLEN BURNIE, MD. 21061 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JUL 18 1995 | | 32. REGISTRAR'S SIGNATURE | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 21623

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|--|--|---|--|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last) <u>Anne Smith</u> | | | | 2. DATE OF DEATH MONTH <u>July</u> DAY <u>15</u> YEAR <u>1993</u> | | 3. TIME OF DEATH <u>1:15</u> <u>PM</u> | |
| 4. SOCIAL SECURITY NUMBER <u>100-32-4369</u> | | 5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F | 6. AGE (In yrs. last birthday) <u>90</u> YRS. | IF UNDER 1 YEAR MONTHS <u> </u> DAYS <u> </u> | IF UNDER 24 HRS. HOURS <u> </u> MIN. <u> </u> | 7. DATE OF BIRTH (Month, Day, Year) <u>Aug 17, 1904</u> | |
| 8. BIRTHPLACE (State or Foreign Country) <u>N.Y.</u> | | | | 9a. FACILITY NAME (If not institution, give street and number) <u>Charlestown Care Center</u> | | 9b. CITY, TOWN OR LOCATION OF DEATH <u>Catonsville</u> | |
| 9c. COUNTY OF DEATH <u>Baltimore</u> | | | | RESIDENCE OF DECEDENT | | | |
| 10a. STATE <u>Md</u> | | 10b. COUNTY <u>Baltimore</u> | | 10c. CITY, TOWN OR LOCATION <u>Catonsville</u> | | 10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | |
| 10e. STREET AND NUMBER <u>715 Maiden Choice Lane</u> | | | | 10f. ZIP CODE <u>21228</u> | | 10g. CITIZEN OF WHAT COUNTRY? <u>USA</u> | |
| 11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: <u>white</u> | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <u>12</u> College (1-4 or 5+) <u>4</u> | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <u>School Teacher</u> | | 16b. KIND OF BUSINESS/INDUSTRY <u>Baltimore City</u> | | | |
| 17. FATHER'S NAME (First, Middle, Last) <u>John F. Smith</u> | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) <u>Mary Campbell</u> | | | |
| 19a. INFORMANT'S NAME (Type/Print) <u>John Morrison</u> | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>5807 Clearspring Rd. Balto, Md. 21212</u> | | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <u>St. John's Cemetery</u> | | DATE <u>7/20</u> | | 20c. LOCATION — City or Town, State <u>Long Island, N.Y.</u> | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <u>Robert S. Quilley</u> | | | | 22. NAME AND ADDRESS OF FACILITY <u>Sterling Ashton Funeral Home</u> <u>736 Edmondson Avenue, Balto, Md. 21228</u> | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <u>Pneumonia</u> Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. <u>Stroke</u> b. <u> </u> c. <u> </u> d. <u> </u> | | | | | | | Approximate interval Between Onset and Death <u>days</u> <u>months</u> |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u> </u> | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | | | | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/> | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY <u>M</u> | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER <u>MD</u> | | | | 29c. LICENSE NUMBER <u>D47447</u> | | 29d. DATE SIGNED (Month, Day, Year) <u>July 16, 1993</u> | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <u>Andrew Lazzari, Charlestown Care Center, Maiden Choice Lane, Catonsville, MD</u> | | | | | | | |
| 31. DATE FILED (Month, Day, Year) <u>JUL 18 1993</u> | | | | 32. REGISTRAR'S SIGNATURE <u>John Andrew Lazzari</u> | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 21624

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|--|--|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last) <u>Ruth G. Spake</u> | | | | 2. DATE OF DEATH MONTH <u>July</u> DAY <u>15</u> YEAR <u>1995</u> | | 3. TIME OF DEATH <u>5:49 P M</u> | |
| 4. SOCIAL SECURITY NUMBER <u>246-16-3043</u> | | 5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 5. AGE (In yrs. last birthday) <u>72</u> YRS. | | 7. DATE OF BIRTH (Month, Day, Year) <u>Sept. 5, 1922</u> | |
| 9a. FACILITY NAME (If not institution, give street and number) <u>Bayview Medical Center</u> | | | | 9b. CITY, TOWN OR LOCATION OF DEATH <u>Baltimore</u> | | 9c. COUNTY OF DEATH <u>N/A</u> | |
| 10a. STATE <u>Md.</u> | | | | 10b. COUNTY <u>Baltimore</u> | | 10c. CITY, TOWN OR LOCATION <u>Dundalk</u> | |
| 10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | 10e. STREET AND NUMBER <u>2507 Liberty Parkway</u> | | 10f. ZIP CODE <u>21222</u> | |
| 10g. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | | | | 11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | |
| 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | | | 14. RACE — American Indian, Black, White, etc. Specify: <u>White</u> | | 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <u>9th</u> College (1-4 or 5+) <u></u> | |
| 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <u>Homemaker</u> | | | | 16b. KIND OF BUSINESS/INDUSTRY <u>Own Home</u> | | 17. FATHER'S NAME (First, Middle, Last) <u>William E. Loftin</u> | |
| 18. MOTHER'S NAME (First, Middle, Maiden Surname) <u>Lucy Boyles</u> | | | | 19a. INFORMANT'S NAME (Type/Print) <u>William N. Spake</u> | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>2507 Liberty Parkway, Dundalk, Maryland 21222</u> | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <u>Meadowridge Mem. Park 7-19-95 Howard Co., Md.</u> | | 20c. LOCATION — City or Town, State | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <u>Edison W. Parker</u> | | | | 22. NAME AND ADDRESS OF FACILITY <u>Bradley-Ashton Funeral Home, Inc. 2134 Willow Spring Rd., Balto., Md.</u> | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <u>Sepsis</u> DUE TO (OR AS A CONSEQUENCE OF): Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. <u></u> c. <u></u> d. <u></u> | | | | | | | Approximate Interval Between Onset and Death <u>2 days</u> |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>Bladder cancer</u> <u>Ischemic legs</u> DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY <u>M</u> | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER <u>Gary S. Hill, M.D.</u> | | | | 29c. LICENSE NUMBER <u>D09277</u> | | 29d. DATE SIGNED (Month, Day, Year) <u>July 17, 1995</u> | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <u>Gary S. Hill, M.D.</u> <u>Johns Hopkins Bayview Medical Center</u> <u>4940 Eastern Ave Balt, MD 21204</u> | | | | | | | |
| 31. DATE FILED (Month, Day, Year) <u>JUL 18 1995</u> | | | | 32. REGISTRAR'S SIGNATURE <u>Johanna R. Randal</u> | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

ITEMS: 23 PART I, 27, 28a-f, PER MEO FILM G-725 7/27/95 t.t

1. FOR
STATE
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

| | | | | | | | | | |
|---|--|--|--|---|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) LAMONT | | | | 2. DATE OF DEATH MONTH JULY DAY 14 YEAR 95 | | | | 3. TIME OF DEATH 7:17 P | |
| 4. SOCIAL SECURITY NUMBER 087-46-0350 | | 5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 39 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) JAN 11 1956 | | 8. BIRTHPLACE (State or Foreign Country) MD | |
| 9a. FACILITY NAME (If not institution, give street and number) LIBERTY MEDICAL CENTER | | | | 9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE CITY | | | | 9c. COUNTY OF DEATH N/A | |
| 10a. STATE MD | | 10b. COUNTY N/A | | 10c. CITY, TOWN OR LOCATION BALTO | | | | 10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | |
| 10e. STREET AND NUMBER 1818 ASHBURTON ST | | | | 10f. ZIP CODE 21216 | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | | | |
| 11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | | | 14. RACE — American Indian, Black, White, etc. Specify: BLACK | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 10TH College (1-4 or 5+) N/A | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) TRUCK DRIVER | | | | 16b. KIND OF BUSINESS/INDUSTRY FOOD | |
| 17. FATHER'S NAME (First, Middle, Last) AARON SANDERS | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) BARBARA SMITH | | | | | |
| 19a. INFORMANT'S NAME (Type/Print) AARON SANDERS | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1818 ASHBURTON ST. BALTO, MD 21216 | | | | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) ARBUTUS MEMORIAL PK 71895 | | | | 20c. LOCATION — City or Town, State BALTO, MD | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Sal March</i> | | | | 22. NAME AND ADDRESS OF FACILITY MARCH F/H-WEST 4300 WABASH AVE | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. COCAINE AND NARCOTIC INTOXICATION DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | | | Approximate interval Between Onset and Death | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input type="checkbox"/> NO | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | |
| 27. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input checked="" type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) FOUND: 7-15-95 | | 28b. TIME OF INJURY FOUND P^M | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED UNKNOWN | |
| | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) FOUND: STREET | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) 1800 BLK. DUKELAND ST. BALTIMORE, MARYLAND | | | |
| 29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. SIGNATURE AND TITLE OF CERTIFIER <i>Theodore M. McKinnis</i> | | | | 29c. LICENSE NUMBER O.C.M.E. | | 29d. DATE SIGNED (Month, Day, Year) JULY 15, 1995 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) THEODORE MCKINNIS 111 Penn Street, Baltimore, Maryland 21201 | | | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JUL 18 1995 | | 32. REGISTRAR'S SIGNATURE <i>John D. ...</i> | | | | | | | |

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 21626

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) Samuel Joseph Sabas | | | | 2. DATE OF DEATH MONTH DAY YEAR July 15, 1995 | | 3. TIME OF DEATH 6:25 A M | |
| 4. SOCIAL SECURITY NUMBER 325-03-7004 | | 5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 80 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) May 10, 1915 | |
| 9a. FACILITY NAME (If not institution, give street and number) Medbridge Rehabilitation Center | | | | 9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE | | 9c. COUNTY OF DEATH BALTIMORE | |
| RESIDENCE OF DECEDENT | | | | | | | |
| 10a. STATE MARYLAND | | 10b. COUNTY BALTIMORE | | 10c. CITY, TOWN OR LOCATION PARKVILLE | | 10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| 10a. STREET AND NUMBER 8800 Walther Blvd., Apt. 2214 | | | | 10f. ZIP CODE 21234-9009 | | 10g. CITIZEN OF WHAT COUNTRY? USA | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES WW II | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: WHITE | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 4 | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Captain | | 16b. KIND OF BUSINESS/INDUSTRY Merchant Marines | | | |
| 17. FATHER'S NAME (First, Middle, Last) Samuel Sabas | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Birgitta Shimkus | | | |
| 19a. INFORMANT'S NAME (Type/Print) Helen A. Sabas | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8800 Walther Blvd., Apt. 2214, Parkville 21234-9009 | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory, or other place) Dulaney Valley Mem. Gardens 18 JULY | | 20c. LOCATION — City or Town, State TIMONIUM, MD | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Bryan W. Clary | | 22. NAME AND ADDRESS OF FACILITY Lemmon Funeral Home of Dulaney Valley, Inc. 10 W. Padonia Rd., Timonium, MD 21093 | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → GASTROINTESTINAL LONG DISEASE Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28d. DESCRIBE HOW INJURY OCCURRED | | | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. SIGNATURE AND TITLE OF CERTIFIER Stephen Selinger, M.D. | | 29c. LICENSE NUMBER 023717 | | 29d. DATE SIGNED (Month, Day, Year) 7/17/95 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Stephen Selinger, M.D., 5601 Loch Raven Blvd., Suite 512, Balto., MD 21239 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JUL 18 1995 | | | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial/transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 21627

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | |
|---|--|---|---|---|--|--|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) MIRIAM | | | | 2. DATE OF DEATH MONTH JULY DAY 13 YEAR 1995 | | | | 3. TIME OF DEATH 8:34pm M | |
| 4. SOCIAL SECURITY NUMBER 219-10-3578 | | 5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 88 YRS. | | 7. DATE OF BIRTH MONTH MARCH DAY 10 YEAR 1907 | | 8. BIRTHPLACE (State or Foreign Country) MARYLAND | |
| 9a. FACILITY NAME (If not institution, give street and number) SINAI HOSPITAL | | | | 9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE | | | | 9c. COUNTY OF DEATH N/A | |
| RESIDENCE OF DECEDENT | | | | | | | | | |
| 10a. STATE MARYLAND | | 10b. COUNTY N/A | | 10c. CITY, TOWN OR LOCATION BALTIMORE | | | | 10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 10e. STREET AND NUMBER 1190 W. NORTHERN PARKWAY, APT. 427 | | | | 10f. ZIP CODE 21210 | | 10g. CITIZEN OF WHAT COUNTRY? USA | | | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | | 14. RACE — American Indian, Black, White, etc. Specify: WHITE | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) College | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) HOUSEWIFE | | | 16b. KIND OF BUSINESS/INDUSTRY OWN HOME | | | |
| 17. FATHER'S NAME (First, Middle, Last) LOUIS GOLDSTEIN | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) JENNIE SCHEIN | | | | | |
| 19a. INFORMANT'S NAME (Type/Print) MRS. ALMA THIMAN | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 14 STONEHENGE CIRCLE BALTIMORE, MD 21208 | | | | | |
| 20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, funeral home, etc.) BALTIMORE HEBREW | | | 20c. LOCATION — City or Town, State 7-16-1995 BALTIMORE, MD | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Gay Alan Louis</i> | | | | 22. NAME AND ADDRESS OF FACILITY SOL LEVINSON & BROS., INC. 6010 REISTERSTOWN ROAD BALTIMORE, MD 21215 | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, stroke, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Dissection of Aorta (Thoracic) DUE TO (OR AS A CONSEQUENCE OF): b. Hypertensive arteriosclerotic cardiovascular disease DUE TO (OR AS A CONSEQUENCE OF): c. Hyperlipidemia DUE TO (OR AS A CONSEQUENCE OF): d. | | | | | | | | Approximate Interval Between Onset and Death 36hr | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED | |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER <i>Jerome Koepfel MD</i> | | | | 29c. LICENSE NUMBER D 08297 | | 29d. DATE SIGNED (Month, Day, Year) 7/14/95 | | | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Jerome Koepfel MD, 222 West Cold Spring Lane Balto, MD 21210 | | | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JUL 18 1995 | | | | 32. REGISTRAR'S SIGNATURE <i>John Brudenial</i> | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 21628

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) GEORGE SEYMOUR SR. | | | | 2. DATE OF DEATH MONTH 7 DAY 15 YEAR 1995 | | 3. TIME OF DEATH 0930 M | |
| 4. SOCIAL SECURITY NUMBER 216-09-8620 | | 5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 81 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 5/15/14 | |
| 8. BIRTHPLACE (State or Foreign Country) Maryland | | | | 9. COUNTY OF DEATH BALTIMORE | | | |
| 9a. FACILITY NAME (If not institution, give street and number) JOHNS HOPKINS BAYVIEW M.C. | | | | 9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE | | | |
| 10a. STATE Md. | | | | 10b. COUNTY Baltimore | | 10c. CITY, TOWN OR LOCATION Essex | |
| 10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | 10e. STREET AND NUMBER 309 S. Lorraine Ave. | | | |
| 10f. ZIP CODE 21221 | | | | 10g. CITIZEN OF WHAT COUNTRY? USA | | | |
| 11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 10th | | 15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Auto Worker | | 16. KIND OF BUSINESS/INDUSTRY GM | | | |
| 17. FATHER'S NAME (First, Middle, Last) Charles Seymour | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Susie Kirby | | | |
| 19a. INFORMANT'S NAME (Type/Print) George Seymour Jr. | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 415 Beck Ave. Baltimore Md. 21221 | | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Oak Lawn Cemetery 7/18/95 | | 20c. LOCATION — City or Town, State Baltimore Md. | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE R. Terry Connelly | | | | 22. NAME AND ADDRESS OF FACILITY Connelly Funeral Home of Essex 300 Mace Ave. Baltimore Md. 21221 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | | | | | | | |
| a. HEMORRHAGE | | | | | | | |
| DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| b. AORTIC ANEURYSM | | | | | | | |
| DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| c. CIRRHOSIS OF LIVER | | | | | | | |
| DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| d. CARDIAC DISEASE | | | | | | | |
| DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. CIRRHOSIS OF LIVER CARDIAC DISEASE | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | | | | |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | | | | |
| 26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | |
| 27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER Peter Mattei MD Surgery Chief Resident | | | | 29c. LICENSE NUMBER D428037 | | 29d. DATE SIGNED (Month, Day, Year) 7/15/95 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Peter Mattei, JOHNS HOPKINS BAYVIEW MEDICAL CENTER | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JUL 18 1995 | | | | 32. REGISTRAR'S SIGNATURE John D. ... | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 21629

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) CATHERINE SIMMS | | | | 2. DATE OF DEATH MONTH JULY DAY 13 YEAR 1995 | | 3. TIME OF DEATH 11:30p M | |
| 4. SOCIAL SECURITY NUMBER 220-18-7645 | | 5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 88 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) March 2, 1907 | |
| 9a. FACILITY NAME (If not institution, give street and number) 7157 Eastbrook Ave. | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Baltimore | | 9c. COUNTY OF DEATH Baltimore | |
| RESIDENCE OF DECEDENT | | | | | | | |
| 10a. STATE Md. | | 10b. COUNTY Baltimore | | 10c. CITY, TOWN OR LOCATION Baltimore | | 10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| 10e. STREET AND NUMBER 7157 Eastbrook Ave. | | | | 10f. ZIP CODE 21224 | | 10g. CITIZEN OF WHAT COUNTRY? USA | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 4th College (1-4 or 5+) | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Housewife | | 16b. KIND OF BUSINESS/INDUSTRY own home | | | |
| 17. FATHER'S NAME (First, Middle, Last) Charles Horn | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Alice Fowler | | | |
| 19a. INFORMANT'S NAME (Type/Print) Carolyn Blackburn | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7157 Eastbrook Ave. Baltimore Md. 21224 | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Oak Lawn Cemetery | | DATE 7/17/95 | | 20c. LOCATION — City or Town, State Baltimore MD. | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE R. Terry Connolly | | | | 22. NAME AND ADDRESS OF FACILITY Connolly Funeral Home of Essex 300 Mace Ave. Baltimore MD. 21221 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | | a. CARDIAC ARRHYTHMIA DUE TO (OR AS A CONSEQUENCE OF): | | | | Approximate interval Between Onset and Death 2 MINUTES | |
| Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | b. CORONARY ARTERY DISEASE DUE TO (OR AS A CONSEQUENCE OF): | | | | 20 YEARS | |
| | | c. _____ DUE TO (OR AS A CONSEQUENCE OF): | | | | | |
| | | d. _____ DUE TO (OR AS A CONSEQUENCE OF): | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Dementia Hypertension ARRIAL FIBRILLATION | | | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| | | 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER Matthew K... MD | | | | 29c. LICENSE NUMBER 94010 | | 29d. DATE SIGNED (Month, Day, Year) JULY 14, 1995 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) MATT KANE MD JOWS HOPKINS BAYVIEW MEDICAL CENTER | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JUL 18 1995 | | | | 32. REGISTRAR'S SIGNATURE John Andrew Randall | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760



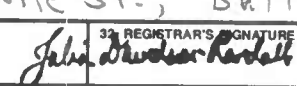
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 21630

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) Michael JOSEPH SZYMANSKI, SR. | | | | 2. DATE OF DEATH MONTH July DAY 15 YEAR 1995 | | 3. TIME OF DEATH 1:35 a.m. | |
| 4. SOCIAL SECURITY NUMBER 216-03-0911 | | 5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 80 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) Sept. 17, 1914 | |
| 8. BIRTHPLACE (State or Foreign Country) Maryland | | | | 9a. FACILITY NAME (If not institution, give street and number) Franklin Square Hospital Center | | 9b. CITY, TOWN OR LOCATION OF DEATH Rossville | |
| 9c. COUNTY OF DEATH Baltimore | | | | 10a. STATE Maryland | | 10b. COUNTY Baltimore | |
| 10c. CITY, TOWN OR LOCATION Dundalk | | | | 10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 10e. STREET AND NUMBER 7305 Manchester Road | |
| 10f. ZIP CODE 21222 | | | | 10g. CITIZEN OF WHAT COUNTRY? United States | | | |
| 11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, OIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 9 years College (1-4 or 5+) College | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Crane Operator | | 16b. KIND OF BUSINESS/INDUSTRY Copper and Brass | | | |
| 17. FATHER'S NAME (First, Middle, Last) Isidore Szymanski | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Helen Nowak | | | |
| 19a. INFORMANT'S NAME (Type/Print) Mrs. Gladys I. Szymanski | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7305 Manchester Road Dundalk, Maryland 21222 | | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Sacred Heart of Jesus Cem. 7/18 | | 20c. LOCATION — City or Town, State Dundalk, Maryland | | 20d. DATE 7/18 | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE  | | | | 22. NAME AND ADDRESS OF FACILITY Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Avenue Dundalk, Maryland 21222 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Pulmonary embolus DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): Approximate Interval Between Onset and Death 5 minutes | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Idiopathic thrombocytopenia Congestive heart failure DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | 29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER  MD PhD | | | | 29c. LICENSE NUMBER D42336 | | 29d. DATE SIGNED (Month, Day, Year) 7/15/95 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 600 N. Wolfe St., Baltimore, MD 21205 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JUL 18 1995 | | | | 32. REGISTRAR'S SIGNATURE  | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95-4131-510
B.K.S

95 21631

1 - FOR
STATE
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

| | | | | | | | |
|--|--|---|---|---|--------------------------------|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) EDWARD SMITH JR. | | | | 2. DATE OF DEATH JULY 15, 1995 | | 3. TIME OF DEATH 1311 P M | |
| 4. SOCIAL SECURITY NUMBER 220-64-4437 | | 5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | 6. AGE (In yrs. last birthday) 26 YRS. | IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. | IF UNDER 24 HRS. HOURS MIN. | 7. DATE OF BIRTH SEPT 13, 1968 | |
| 9a. FACILITY NAME (If not institution, give street and number) UNIVERSITY HOSPITAL S.T.U | | | | 9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE CITY | | 9c. COUNTY OF DEATH BALTIMORE CITY | |
| RESIDENCE OF DECEDENT | | | | | | | |
| 10a. STATE MARYLAND | | 10b. COUNTY BALTIMORE CITY | | 10c. CITY, TOWN OR LOCATION BALTIMORE | | 10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 10e. STREET AND NUMBER 5329 CARRIAGE COURT | | | | 10f. ZIP CODE 21229 | | 10g. CITIZEN OF WHAT COUNTRY? UNITED STATES | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: BLACK | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (14 or 5+) 12 | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) FOREMAN | | 16b. KIND OF BUSINESS/INDUSTRY WASTE WATER BALTO. CITY | | | |
| 17. FATHER'S NAME (First, Middle, Last) EDWARD SMITH, SR. | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) LINDA FLOWERS | | | |
| 19a. INFORMANT'S NAME (Type/Print) CONNIE SMITH | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5329 CARRIAGE COURT BALTIMORE, MARYLAND 21229 | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) ARBUTUS MEM. PK. 7-20-95 | | 20c. LOCATION — City or Town, State ARBUTUS, MARYLAND | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Calvin L. Williams</i> | | | | 22. NAME AND ADDRESS OF FACILITY CALVIN L. WILLIAMS F.S. 270 FREDHILTON (Gary P. March F.H.) PASS BALTO., MD | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. ANOXIC ENCEPHALOPATHY COMPLICATING HANGING DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. | | | | | | | Approximate interval Between Onset and Death |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? XX YES 2 <input type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: XX Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Could not be determined 3 <input checked="" type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) 6/30/95 | | 28b. TIME OF INJURY 4:33 PM | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| | | 28d. DESCRIBE HOW INJURY OCCURRED SUBJECT HANGED SELF | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) JAIL | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) BALTIMORE CITY JAIL, BALTIMORE MD | |
| 29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER <i>John F. Gallo Jr. MD</i> | | | | 29c. LICENSE NUMBER O.C.M.E | | 29d. DATE SIGNED (Month, Day, Year) JULY 16, 1995 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) MARIE F. GALLO JR MD 111 Penn Street, Baltimore, Maryland 21201 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JUL 18 1995 | | | | | | | |

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 21632

ITEM: 1. PER F.H. FILM G-726 8/8/95 t.t

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|--|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) BERNARD IRVIN BERNAR SCHUMAN | | | | 2. DATE OF DEATH MONTH JULY DAY 10 YEAR 1995 | | 3. TIME OF DEATH 1530 M | |
| 4. SOCIAL SECURITY NUMBER 217-09-8573 | | 5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 75 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) Dec. 30, 1919 | |
| 8. BIRTHPLACE (State or Foreign Country) Virginia | | | | 9a. FACILITY NAME (If not Institution, give street and number) Holy Cross Hospital | | 9b. CITY, TOWN OR LOCATION OF DEATH Silver Spring | |
| 9c. COUNTY OF DEATH Montgomery | | | | 10a. STATE Maryland | | 10b. COUNTY Montgomery | |
| 10c. CITY, TOWN OR LOCATION Silver Spring | | | | 10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | 10e. STREET AND NUMBER 1902 Ladd Street | |
| 10f. ZIP CODE 20902 | | | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | | 11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (9-12) -2- College (1-4 or 5+) -2- | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Owner | | 16b. KIND OF BUSINESS/INDUSTRY Ace Parking Service | |
| 17. FATHER'S NAME (First, Middle, Last) Jack Schuman | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Dora Abraham | | | |
| 19a. INFORMANT'S NAME (Type/Print) Shirley Schuman | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1902 Ladd St. Silver Spring, Md. 20902 | | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) King David Mem. Gdns. 7/12 | | 20c. LOCATION — City or Town, State Falls Church, VA. | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i> | | | | 22. NAME AND ADDRESS OF FACILITY LIVES-PEARSON FUNERAL HOMES FALLS CHURCH, VA. 22046 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → sepsis a. DUE TO (OR AS A CONSEQUENCE OF): colon cancer b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Approximate Interval Between Onset and Death 1 week 6 years Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | 29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i> | | | | 29c. LICENSE NUMBER 021463 | | 29d. DATE SIGNED (Month, Day, Year) 7/11/95 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) BRUCE A. JILLAR, MD 2101 Medical Park Dr. Silver Spring MD 20902 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JUL 18 1995 | | | | 32. REGISTRAR'S SIGNATURE <i>[Signature]</i> | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Items 9a, 9b, 10a, 10b, 10c, 10e, 10f, 11, 14, 15, 16a, 16b, 17, 18,

95 21633

19a, 19b, 20a 7-19-95 Film G725 W.H. Per Anatomy Board

FOR
1 - STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | | | | |
|---|--|--|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) Mary E Sears | | | | 2. DATE OF DEATH July 11 1995 | | 3. TIME OF DEATH 7:35 A.M. | |
| 4. SOCIAL SECURITY NUMBER 234-58-1220 | | 5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 38 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 5-28-57 | |
| 9a. FACILITY NAME (If not institution, give street and number) Westminster Nursing Home 1928 Frederick Avenue | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Baltimore Westminster | | 9c. COUNTY OF DEATH Carroll | |
| 10a. STATE Maryland | | 10b. COUNTY Carroll | | 10c. CITY, TOWN OR LOCATION Baltimore Westminster | | 10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 10e. STREET AND NUMBER 4107 Eyre Court 1928 Frederick Avenue | | | | 10f. ZIP CODE 21223 21157 | | 10g. CITIZEN OF WHAT COUNTRY? | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White Black | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 2 Yrs. | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Nursing Assistant | | 16b. KIND OF BUSINESS/INDUSTRY Medical | | | |
| 17. FATHER'S NAME (First, Middle, Last) Harry Andrew Metz | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Audra Virginia Cosner-Metz | | | |
| 19a. INFORMANT'S NAME (Type/Print) Rosa S. Long | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4107 Eyre Court, Westminster, MD. 21157 | | | |
| 20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input checked="" type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) in state removal | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) | | DATE | | 20c. LOCATION — City or Town, State | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Ronald Wade, Dir. | | | | 22. NAME AND ADDRESS OF FACILITY State Anatomy Board 655 W. Baltimore St., Baltimore, MD. 21201 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Pulmonary Fibrosis DUE TO (OR AS A CONSEQUENCE OF): Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. | | | | | | | Approximate Interval Between Onset and Death long time |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | | | | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER Nayan Vaywala MD | | | | 29c. LICENSE NUMBER D23443 | | 29d. DATE SIGNED (Month, Day, Year) 7-11-95 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) NAYAN VAYWALA 217 Washington Hgts Med CTR Westminster, MD 21157 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JUL 17 1995 | | | | 32. REGISTRAR'S SIGNATURE [Signature] | | | |

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|---|--|--|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) MATILDA Louise STRUCKMAN | | | | 2. DATE OF DEATH JUNE 27 1995 | | 3. TIME OF DEATH 11:30 A.M. | |
| 4. SOCIAL SECURITY NUMBER 214-40-6338 | | 5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | 6. AGE (In yrs. last birthday) 76 YRS. | 7. DATE OF BIRTH 12-22-18 | | 8. BIRTHPLACE (State or Foreign Country) Pennsylvania | |
| 9a. FACILITY NAME (If not institution, give street and number) 15 CHARLES PLAZA APT. 1004 | | | | 9b. CITY, TOWN OR LOCATION OF DEATH baltimore city | | 9c. COUNTY OF DEATH N/A | |
| 10a. STATE Maryland | | | | 10b. COUNTY N/A | | 10c. CITY, TOWN OR LOCATION Baltimore | |
| 10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | 10e. STREET AND NUMBER 15 Charles Plaza- Apt. 1004 | | 10f. ZIP CODE 21201 | |
| 10g. CITIZEN OF WHAT COUNTRY? USA | | | | 11. MARITAL STATUS 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | |
| 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Year or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | | | 14. RACE — American Indian, Black, White, etc. Specify: White | | 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 6+) | |
| 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Nurse | | | | 16b. KIND OF BUSINESS/INDUSTRY Hospital | | 17. FATHER'S NAME (First, Middle, Last) George Struckman | |
| 18. MOTHER'S NAME (First, Middle, Maiden Surname) Lena Barley | | | | 19a. INFORMANT'S NAME (Type/Print) Josephine L. Yauger | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 216 Sunnyside Rd. Bedford, PA. 15522 | |
| 20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) In-state removal | | | | 20b. PLACE AND DATE OF DISPOSITION Metro Crematory Inc. 7-25-95 | | 20c. LOCATION — City or Town, State Baltimore, MD | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Ronald Wade, Dir. | | | | 22. NAME AND ADDRESS OF FACILITY State Anatomy Board 655 W. Baltimore St., -Baltimore, MD. 21201 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Hypertensive atherosclerotic cardiovascular disease DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST | | | | | | | Approximate Interval Between Onset and Death |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | | | | DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/> |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER David R Fowler | | | | 29c. LICENSE NUMBER O.C.M.E. | | 29d. DATE SIGNED (Month, Day, Year) JUNE 28, 1995 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) David R Fowler 111 Penn Street, Baltimore, Maryland 21201 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JUL 17 1995 | | 32. REGISTRAR'S SIGNATURE [Signature] | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

BALTIMORE, MARYLAND 21215-0020

BALTIMORE, MARYLAND 21215-0020

BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 21635

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | | |
|---|--|---|--|---|--|---|--|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last) Amos Thompson, Jr. | | | | 2. DATE OF DEATH MONTH July DAY 15 YEAR 1995 8:00 A M | | | | 3. TIME OF DEATH | | |
| 4. SOCIAL SECURITY NUMBER 212-34-2602 | | 5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 58 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) Mar. 14, 1937 | | 8. BIRTHPLACE (State or Foreign Country) Maryland | | |
| 9a. FACILITY NAME (If not institution, give street and number) 2936 W. Coldspring Lane | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Baltimore | | | | 9c. COUNTY OF DEATH N/A | | |
| 10a. STATE Maryland | | 10b. COUNTY N/A | | 10c. CITY, TOWN OR LOCATION Baltimore | | | | 10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | |
| 10e. STREET AND NUMBER 2936 W. Coldspring Lane # C | | | | 10f. ZIP CODE 21215 | | 10g. CITIZEN OF WHAT COUNTRY? USA | | | | |
| 11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE YEAR OR DATES 7-11-60 to 11-8-61 | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: Black | | | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 2 Years College (1-4 or 5+) Property Supervisor | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Woodstock Job Corp | | 16b. KIND OF BUSINESS/INDUSTRY | | | | |
| 17. FATHER'S NAME (First, Middle, Last) Amos Thompson, Sr. | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Louise Strickland | | | | | | |
| 19a. INFORMANT'S NAME (Type/Print) Blanche Thompson | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2936 W. Coldspring Lane Baltimore, Md 21215 | | | | | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Carrison Crest Vet. Cem. 7/18/95 | | 20c. LOCATION — City or Town, State Owings Mills, Md | | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Sperry Harris | | | | 22. NAME AND ADDRESS OF FACILITY CHATMAN-HARRIS F.H. Baltimore, Md | | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. dehydration DUE TO (OR AS A CONSEQUENCE OF): b. metastatic carcinoma of the colon DUE TO (OR AS A CONSEQUENCE OF): c. _____ DUE TO (OR AS A CONSEQUENCE OF): d. _____ Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | | | | Approximate Interval Between Onset and Death | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/> | | | | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Nomicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 28d. DESCRIBE NOW INJURY OCCURRED | | |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. SIGNATURE AND TITLE OF CERTIFIER Marcia Kane MD | | | | 29c. LICENSE NUMBER D26391 | | 29d. DATE SIGNED (Month, Day, Year) 7/17/95 | | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type/Print) Marcia Kane MD 301 St. Paul Place Balt, Md 21202 | | | | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JUL 18 1995 | | 32. REGISTRAR'S SIGNATURE John [Signature] | | | | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 21636

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) CECELIA (NMN) TRAUT | | | | 2. DATE OF DEATH MONTH 07 DAY 11 YEAR 1995 | | 3. TIME OF DEATH 12:10 A M | |
| 4. SOCIAL SECURITY NUMBER 213-74-6576 | | 5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 91 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 07-17-1903 | |
| 8. BIRTHPLACE (State or Foreign Country) MARYLAND | | 9a. FACILITY NAME (If not institution, give street and number) CROFTON CONVALESCENT CENTER | | 9b. CITY, TOWN OR LOCATION OF DEATH CROFTON | | 9c. COUNTY OF DEATH ANNE ARUNDEL | |
| RESIDENCE OF DECEDENT | | | | | | | |
| 10a. STATE MARYLAND | | 10b. COUNTY ANNE ARUNDEL | | 10c. CITY, TOWN OR LOCATION LINTHICUM | | 10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| 10e. STREET AND NUMBER 508 FOREST VIEW ROAD | | | | 10f. ZIP CODE 21090 | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: WHITE | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 6 College (1-4 or 5+) NONE | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) HOMEMAKER | | 16b. KIND OF BUSINESS/INDUSTRY OWN HOME | | | |
| 17. FATHER'S NAME (First, Middle, Last) GEORGE RAMMES | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) BARBARA MAHR | | | |
| 19a. INFORMANT'S NAME (Type/Print) MRS. RAYMA L. BIGGS | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 508 FOREST VIEW ROAD, LINTHICUM, MARYLAND 21090 | | | |
| 20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) BALTIMORE CEMETERY | | DATE 7/14/95 | | 20c. LOCATION — City or Town, State BALTIMORE, MARYLAND | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | | | | 22. NAME AND ADDRESS OF FACILITY SINGLETON FUNERAL HOME, 1 SECOND AVENUE, S.W., GLEN BURNIE, MD. 21061 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | | a. Congestive Heart Failure DUE TO (OR AS A CONSEQUENCE OF): | | | | | Approximate interval Between Onset and Death 1 year |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | b. DUE TO (OR AS A CONSEQUENCE OF): | | | | | |
| | | c. DUE TO (OR AS A CONSEQUENCE OF): | | | | | |
| | | d. DUE TO (OR AS A CONSEQUENCE OF): | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Pneumonia Stroke | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| | | 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER Paul J Rhoder MD | | | | 29c. LICENSE NUMBER D22028 | | 29d. DATE SIGNED (Month, Day, Year) 7 11 95 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Paul J Rhoder MD 1667 Crofton Center Crofton Md | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JUL 18 1995 | | 32. REGISTRAR'S SIGNATURE John Andrew Randall | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 21637

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) LUVISH TSITRIN | | | | 2. DATE OF DEATH MONTH July DAY 8 YEAR 1995 | | 3. TIME OF DEATH 9:55 P M | |
| 4. SOCIAL SECURITY NUMBER 215-41-0484 | | 5. SEX 1 <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 78 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) Feb. 20, 1917 | |
| 9a. FACILITY NAME (If not institution, give street and number) Suburban Hospital | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Bethesda | | 9c. COUNTY OF DEATH Montgomery | |
| 10a. STATE Maryland | | | | 10b. COUNTY Montgomery | | 10c. CITY, TOWN OR LOCATION Rockville | |
| 10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | | | 10e. STREET AND NUMBER 247 North Van Buren Street | | | |
| 10f. ZIP CODE 20850 | | | | 10g. CITIZEN OF WHAT COUNTRY? Ukraine | | | |
| 11. MARITAL STATUS 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) | | 15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Engineer | | 15b. KIND OF BUSINESS/INDUSTRY Mechanical | | | |
| 17. FATHER'S NAME (First, Middle, Last) Ayrum-Aba Tsitritin | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Mindlya (Unknown) | | | |
| 19a. INFORMANT'S NAME (Type/Print) Margarita Tsitritin | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 247 N. Van Buren St., Rockville, Maryland 20850 | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Judean Memorial Gardens 7/11/1995 | | 20c. LOCATION — City or Town, State Olney, Maryland | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Donald C. Stottmeyer | | | | 22. NAME AND ADDRESS OF FACILITY STEIN HEBREW MEMORIAL FUNERAL HOME, INC. 232 CARROLL ST, NW, WASHINGTON, DC 20012 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. SEPSIS b. Renal Failure c. Liver Failure d. POST OPERATIVE REPAIR ABDOMINAL ANEURYSM | | | | Approximate Interval Between Onset and Death 3 DAYS 2 WKS 3 WKS 3 WKS | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28d. DESCRIBE HOW INJURY OCCURRED | | | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | 29b. SIGNATURE AND TITLE OF CERTIFIER JAMES SALANDER, M.D. | | 29c. LICENSE NUMBER D39064 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) JAMES SALANDER, M.D., 11119 Rockville Pk., #204, Rockville, MD 20852 | | | | 29d. DATE SIGNED (Month, Day, Year) July 9 1995 | | | |
| 31. DATE FILED (Month, Day, Year) JUL 18 1995 | | 32. REGISTRAR'S SIGNATURE Juli Anderson-Randall | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

P.O. BOX 68760

3

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. The first part of the report deals with the general situation of the country and the progress of the work during the year. It is a summary of the work done and the results obtained. It is a general statement of the work done and the results obtained.

2. The second part of the report deals with the specific work done during the year. It is a detailed statement of the work done and the results obtained. It is a detailed statement of the work done and the results obtained.

3. The third part of the report deals with the financial statement of the work done during the year. It is a statement of the financial statement of the work done during the year. It is a statement of the financial statement of the work done during the year.

4. The fourth part of the report deals with the conclusions drawn from the work done during the year. It is a statement of the conclusions drawn from the work done during the year. It is a statement of the conclusions drawn from the work done during the year.

5. The fifth part of the report deals with the recommendations made for the future work. It is a statement of the recommendations made for the future work. It is a statement of the recommendations made for the future work.

95 21638

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|---|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) Helen Marie Traband | | | | 2. DATE OF DEATH MONTH DAY YEAR June 28, 1995 | | 3. TIME OF DEATH 9:30 PM | |
| 4. SOCIAL SECURITY NUMBER 213-48-6794 | | 5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 78 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) Dec. 20, 1916 | |
| 9a. FACILITY NAME (If not institution, give street and number) 1851 John Drive | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Edgewood | | 9c. COUNTY OF DEATH Harford | |
| RESIDENCE OF DECEDENT | | | | | | | |
| 10a. STATE Maryland | | 10b. COUNTY Harford | | 10c. CITY, TOWN OR LOCATION Edgewood | | 10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| 10e. STREET AND NUMBER 1851 John Drive | | | | 10f. ZIP CODE 21040 | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (9-12) 12 College (1-4 or 5+) 12 | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Owner | | 16b. KIND OF BUSINESS/INDUSTRY Tavern Owner | |
| 17. FATHER'S NAME (First, Middle, Last) Anthony Simmel | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Catherine Bair | | | |
| 19a. INFORMANT'S NAME (Type/Print) George R. Traband | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1851 John Drive Edgewood, Maryland 21040 | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Dulaney Valley Mem. July 3, 1995 | | DATE July 3, 1995 | | 20c. LOCATION — City or Town, State Baltimore, Maryland | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>E. F. Lassahn</i> | | | | 22. NAME AND ADDRESS OF FACILITY E. F. Lassahn Funeral Home 11750 Belair Road Kingsville, Md. 21087 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Congestive heart failure DUE TO (OR AS A CONSEQUENCE OF): b. Aortic regurgitation DUE TO (OR AS A CONSEQUENCE OF): c. Ascending aortic aneurysm DUE TO (OR AS A CONSEQUENCE OF): d. Approximate Interval Between Onset and Death 2 years 4 years 4 years Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28d. DESCRIBE HOW INJURY OCCURRED | | | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | 28g. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER <i>Michael N. Drossner, M.D.</i> | | | | 29c. LICENSE NUMBER MD D32288 | | 29d. DATE SIGNED (Month, Day, Year) 6/29/95 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Michael N. Drossner, M.D. 104 Plumtree Rd, Suite 110 Bel Air MD | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JUL 18 1995 <i>John Michael Rindel</i> 21015 | | | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 21639

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|--|--|--|--|--|---|
| 1. DECEDENT'S NAME (First, Middle, Last) Ada L. Twigg | | | | 2. DATE OF DEATH MONTH DAY YEAR 7 9 95 | | 3. TIME OF DEATH 2:45 p. M | |
| 4. SOCIAL SECURITY NUMBER 218-38-2381 | | 5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 100 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 9-7-1894 | |
| 8. BIRTHPLACE (State or Foreign Country) Maryland | | | | 9a. FACILITY NAME (If not institution, give street and number) Cumberland Nursing Center | | 9b. CITY, TOWN OR LOCATION OF DEATH Cumberland | |
| 9c. COUNTY OF DEATH Alleghany | | | | 10a. STATE Maryland | | 10b. COUNTY Cumberland | |
| 10c. CITY, TOWN OR LOCATION Cumberland | | | | 10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 10e. STREET AND NUMBER 114 Harrison Street | |
| 10f. ZIP CODE 21502 | | | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | | 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO Specify: | | | |
| 14. RACE — American Indian, Black, White, etc. Specify: White | | | | 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) | | | |
| 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) | | | | 16b. KIND OF BUSINESS/INDUSTRY | | | |
| 17. FATHER'S NAME (First, Middle, Last) | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) | | | |
| 19a. INFORMANT'S NAME (Type/Print) Dorothy Vanscoy | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 530 Ruhl Avenue—Cumberland, Maryland 21502 | | | |
| 20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input checked="" type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) | | 20c. LOCATION — City or Town, State | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Ronald Wade, Dir. | | | | 22. NAME AND ADDRESS OF FACILITY State Anatomy Board 655 W. Baltimore St., Baltimore, MD. 21201 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Coronary Artery disease DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. | | | | | | | Approximate interval Between Onset and Death 10 years |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | |
| 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | 28d. DESCRIBE NOW INJURY OCCURRED | | | |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER [Signature] | | | | 29c. LICENSE NUMBER D33280 | | 29d. DATE SIGNED (Month, Day, Year) July 9, 1995 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JUL 17 1995 | | | | 32. REGISTRAR'S SIGNATURE [Signature] | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

EVANGELICAL BOARD

OF THE AMERICAN MISSIONS SOCIETY

95 21640

1. FOR
STATE
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | | | |
|---|--|---|--|---|--|---|---|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) WILLIAM L. UNRUE, JR. | | | | 2. DATE OF DEATH MONTH JULY DAY 13 YEAR 1995 | | 3. TIME OF DEATH 4:00AM M | | | | | |
| 4. SOCIAL SECURITY NUMBER 213-10-4111 A | | 5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 77 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) Feb. 22, 1918 | | 8. BIRTHPLACE (State or Foreign Country) Virginia | | | |
| 9a. FACILITY NAME (If not institution, give street and number) 1 Winona Avenue | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Dundalk | | | 9c. COUNTY OF DEATH Baltimore | | | | |
| 10a. STATE Md. | | 10b. COUNTY Baltimore | | 10c. CITY, TOWN OR LOCATION Dundalk | | | 10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | |
| 10e. STREET AND NUMBER 1 Winona Ave. | | | | 10f. ZIP CODE 21222 | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | | | | | |
| 11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | | 14. RACE — American Indian, Black, White, etc. Specify: White | | | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) College | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Supervisor | | | 16b. KIND OF BUSINESS/INDUSTRY Steel Company | | | | | | |
| 17. FATHER'S NAME (First, Middle, Last) William L. Unrue, Sr. | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Nannie Lawrence | | | | | | | |
| 19a. INFORMANT'S NAME (Type/Print) Mary Brummet | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8192 Gum Tree Dr., Dundalk, Md. 21222 | | | | | | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Meadowridge Memorial Pk. 7-15-95 Howard Co., Md | | 20c. LOCATION — City or Town, State 21222 | | 20d. DATE 21222 | | | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Elinor U. Perkins | | | | 22. NAME AND ADDRESS OF FACILITY Bradley-Ashton Funeral Home, Inc. 2134 Willow Spring Rd., Balto., Md. | | | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → PNEUMONIA Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. DUE TO (OR AS A CONSEQUENCE OF): ASPIRATION b. DUE TO (OR AS A CONSEQUENCE OF): CEREBROVASCULAR ACCIDENT c. DUE TO (OR AS A CONSEQUENCE OF): HYPERTENSION d. ANEMIA | | | | | | | | Approximate Interval Between Onset and Death 3 DAYS 1 MONTH 1 YEAR 10 YEARS | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ANEMIA | | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | | | |
| 27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED | | | |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| 29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER Deepak Seth, M.D. | | | | | | 29c. LICENSE NUMBER D33407 | | 29d. DATE SIGNED (Month, Day, Year) 7/13/95 | | | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Deepak Seth 201 Wise Avenue, Dundalk, Md. 21222 | | | | | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JUL 18 1995 | | | | 32. REGISTRAR'S SIGNATURE John Anderson Randall | | | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760
BALTIMORE, MARYLAND 21215-0020
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95-0419-033

DWG

UNK 95-024

ITEMS: 1-8, 10a-19b, PER MEO FILM G-727 9/1/95 t.t

95 21641

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

| | | | | | | | |
|--|--|---|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) HARRY ELLSWORTH JONES | | | | 2. DATE OF DEATH MONTH JAN. DAY 22 YEAR 95 | | 3. TIME OF DEATH 4:40 P M | |
| 4. SOCIAL SECURITY NUMBER 578-30-6321 | | 5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 68 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) AUG. 15, 1926 | |
| 9a. FACILITY NAME (If not institution, give street and number) WOODED AREA NORTHVIEW DRIVE NEAR RTE 197 | | | | 9b. CITY, TOWN OR LOCATION OF DEATH BOWIE | | 9c. COUNTY OF DEATH PRINCE GEORGES | |
| RESIDENCE OF DECEDENT | | | | | | | |
| 10a. STATE WASH. DC | | 10b. COUNTY | | 10c. CITY, TOWN OR LOCATION WASHINGTON, D.C. | | 10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | |
| 10e. STREET AND NUMBER 1205 "C" ST., N.E. | | | | 10f. ZIP CODE 20001 | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES UNKNOWN | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: BLACK | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (9-12) UNKNOWN College (1-4 or 5+) UNKNOWN | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) UNKNOWN | | 16b. KIND OF BUSINESS/INDUSTRY UNKNOWN | |
| 17. FATHER'S NAME (First, Middle, Last) FRANK FRANCIS JONES, SR. | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) MARGARET ELIZABETH SIMMS | | | |
| 19a. INFORMANT'S NAME (Type/Print) JEAN WOOD | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12621 CAMBLETON DR. UPPER MARLBORO, MD. 20772 | | | |
| 20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input checked="" type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) in state removal | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) DATE | | 20c. LOCATION — City or Town, State | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Ronald Wade, Dir. | | | | 22. NAME AND ADDRESS OF FACILITY State Anatomy Board 655 W. Baltimore St., Baltimore, MD. 21201 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. NO ANATOMIC CAUSE OF DEATH DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. | | | | | | | Approximate Interval Between Onset and Death |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) AT SCENE FOUND IN WOODS | | | | | |
| 27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input checked="" type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) FOUND 1/22/95 | | 28b. TIME OF INJURY 1:10 P M | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) FOUND IN WOODS | | | | 28d. DESCRIBE HOW INJURY OCCURRED UNKNOWN | | | |
| 28e. LOCATION (Street and Number or Rural Route Number, City or Town, State) NORTHVIEW DRIVE HEALTH CTR DR. E RT. 197 | | | | | | | |
| 29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER Dorisee Breifkell | | | | 29c. LICENSE NUMBER O.C.M.E. | | 29d. DATE SIGNED (Month, Day, Year) FEB. 22/95 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Margarita Korell M.D. 111 Penn Street, Baltimore, Maryland 21201 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JUL 17 1995 | | 32. REGISTRAR'S SIGNATURE John Charles Randall | | | | | |

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | | | | | | | |
|--|--|---|--|--|---|---|--------------------------------|--|--|---|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) | | | | 2. DATE OF DEATH MONTH DAY YEAR APRIL 27, 1995 | | | | 3. TIME OF DEATH 11:58 A M | | | | | | | |
| 4. SOCIAL SECURITY NUMBER | | 5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | 6. AGE (in yrs. last birthday) YRS. | | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS. HOURS MIN. | | 7. DATE OF BIRTH (Month, Day, Year) | 8. BIRTHPLACE (State or Foreign Country) | | | | | |
| 9a. FACILITY NAME (If not institution, give street and number) 801 KEY HIGHWAY - INNER HARBOR RESIDENCE OF DECEDENT | | | | | 9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE | | | | 9c. COUNTY OF DEATH | | | | | | |
| 10a. STATE | | 10b. COUNTY | | 10c. CITY, TOWN OR LOCATION | | | | 10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | | | | |
| 10e. STREET AND NUMBER | | | | 10f. ZIP CODE | | | | 10g. CITIZEN OF WHAT COUNTRY? | | | | | | | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO Specify: | | | | 14. RACE — American Indian, Black, White, etc. Specify: | | | | | | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) | | | | 15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) | | | | 15b. KIND OF BUSINESS/INDUSTRY | | | | | | | |
| 17. FATHER'S NAME (First, Middle, Last) | | | | | 16. MOTHER'S NAME (First, Middle, Maiden Surname) | | | | | | | | | | |
| 19a. INFORMANT'S NAME (Type/Print) | | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) | | | | | | | | | | |
| 20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) <u>In state removal</u> | | | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) | | OATE | | 20c. LOCATION — City or Town, State | | | | | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <u>Ronald Wade, Dir.</u> | | | | 22. NAME AND ADDRESS OF FACILITY State Anatomy Board 655 W. Baltimore St., Baltimore, MD. 21201 | | | | | | | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <u>DROWNING</u> DUE TO (OR AS A CONSEQUENCE OF): Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. | | | | | | | | | | Approximate Interval Between Onset and Death | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | | | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) <u>INNER HARBOR</u> | | | | | | | | | | | | | |
| 27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input checked="" type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 27a. DATE OF INJURY (Month, Day, Year) <u>4/27/1995</u> | | 27b. TIME OF INJURY <u>11:40 A</u> | | 27c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 27d. DESCRIBE HOW INJURY OCCURRED <u>SUBJECT DROWNED</u> | | | | | | | |
| 27e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) <u>FOUND IN WATER</u> | | | | 27f. LOCATION (Street and Number or Rural Route Number, City, Town, State) <u>INNER HARBOR BALTIMORE, MARYLAND</u> | | | | | | | | | | | |
| 29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | | 29b. SIGNATURE AND TITLE OF CERTIFIER <u>Dennis J. Chute</u> | | 29c. LICENSE NUMBER <u>O.C.M.E.</u> | | 29d. DATE SIGNED (Month, Day, Year) <u>MAY 11, 1995</u> | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <u>DENNIS J. CHUTE M.D. 111 Penn Street, Baltimore, Maryland 21201</u> | | | | | | | | | | | | | | | |
| 31. DATE FILED (Month, Day, Year) <u>JUL 17 1995</u> | | | | 32. REGISTRAR'S SIGNATURE <u>[Signature]</u> | | | | | | | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95-2375-510

blh

95-112

95 21643

ITEMS: 23 PART I, II, 27, 28a-f, PER MEO FILM G-725 7/21/95 t.t

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | | | | | | | |
|--|--|---|--|---|--|--|--|---|--|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) | | | | 2. DATE OF DEATH MONTH DAY YEAR April 23 1995 | | | | 3. TIME OF DEATH 1103 AM | | | | | | | |
| 4. SOCIAL SECURITY NUMBER | | 5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 8. AGE (In yrs. last birthday) YRS. | | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS. HOURS MIN. | | 7. DATE OF BIRTH (Month, Day, Year) | | 6. BIRTHPLACE (State or Foreign Country) | | | |
| 9a. FACILITY NAME (If not institution, give street and number) Pier 6- in water | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Baltimore | | | | 9c. COUNTY OF DEATH | | | | | | | |
| 10a. STATE | | | | 10b. COUNTY | | | | 10c. CITY, TOWN OR LOCATION | | | | 10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | |
| 10e. STREET AND NUMBER | | | | 10f. ZIP CODE | | | | 10g. CITIZEN OF WHAT COUNTRY? | | | | | | | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: Other unknown | | | | | | | | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) | | | | 15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) | | | | 15b. KIND OF BUSINESS/INDUSTRY | | | | | | | |
| 17. FATHER'S NAME (First, Middle, Last) | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) | | | | | | | | | | | |
| 19a. INFORMANT'S NAME (Type/Print) | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) | | | | | | | | | | | |
| 20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) in state removal | | | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) | | | | DATE | | 20c. LOCATION — City or Town, State | | | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Ronald Wade, Dir. | | | | 22. NAME AND ADDRESS OF FACILITY State Anatomy Board 655 W. Baltimore St., Baltimore, MD. 21201 | | | | | | | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. DROWNING DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | | | | | | | Approximate Interval Between Onset and Death | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE | | | | | | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | | | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> OOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) at scene | | | | | | | | | | | |
| 27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input checked="" type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | | | 28a. DATE OF INJURY (Month, Day, Year) FOUND: 4-23-95 | | 28b. TIME OF INJURY 10:45 AM | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED SUBJECT DROWNED | | | | | |
| 29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | 29b. SIGNATURE AND TITLE OF CERTIFIER Theodore M. Kaufman | | | | 29c. LICENSE NUMBER O.C.M.E. | | 29d. DATE SIGNED (Month, Day, Year) April 24 1995 | | | | | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) THE ONE WIFE 111 Penn Street, Baltimore, Maryland 21201 | | | | | | | | | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JUL 17 1995 | | | | 32. REGISTRAR'S SIGNATURE John Charles Randall | | | | | | | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) Clifton R. Veney | | | | 2. DATE OF DEATH MONTH July DAY 15 YEAR 1995 | | 3. TIME OF DEATH 3:00 A.M. | |
| 4. SOCIAL SECURITY NUMBER 228-44-7886 | | 5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 59 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) JAN. 9, 1936 | |
| 8a. FACILITY NAME (If not institution, give street and number) North Arundel Hospital | | | | 8b. CITY, TOWN OR LOCATION OF DEATH Glen Burnie | | 8c. COUNTY OF DEATH Anne Arundel | |
| 9. RESIDENCE OF DECEDENT | | | | 10a. STATE MARYLAND | | 10b. COUNTY n.a. | |
| 10c. CITY, TOWN OR LOCATION FORT MEADE | | | | 10d. INSIDE CITY LIMITS <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | 10e. STREET AND NUMBER 7818 CITADEL COURT | |
| 10f. ZIP CODE 21144-1512 | | | | 10g. CITIZEN OF WHAT COUNTRY? UNITED STATES | | 11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES n/a | | | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: BLACK | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 4 years College (1-4 or 5+) 4 years | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) DEPUTY SAFETY MANAGER | | 16b. KIND OF BUSINESS/INDUSTRY FORT MEADE | |
| 17. FATHER'S NAME (First, Middle, Last) CLARENCE VENY | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) CURLINE VENY VENY | | | |
| 19a. INFORMANT'S NAME (Type/Print) FAVE T. VENY | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7818 CITADEL COURT, BALTIMORE, MD 212-21144-1512 | | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) ACCOMAC CITY - STAR EAST-20 | | 20c. LOCATION — City or Town, State ACCOMAC CITY, VIRGINIA | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | | | | 22. NAME AND ADDRESS OF FACILITY WM.C. MARCH FH.-1101 E. NORTH - A VEN. AVE. | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. DISSEMINATED INTRAVASCULAR COAGULOPATHY | | | | | | | |
| DUE TO (OR AS A CONSEQUENCE OF): b. SEPTIC SHOCK | | | | | | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST c. CEREBRO VASCULAR ACCIDENT. | | | | | | | |
| DUE TO (OR AS A CONSEQUENCE OF): d. GASTRIC CANCER | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | | | | |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | | | | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/> | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | | | | |
| 26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | |
| 27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | | | | | | |
| 28a. DATE OF INJURY (Month, Day, Year) | | | | | | | |
| 28b. TIME OF INJURY M | | | | | | | |
| 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | | | | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | | | | | | |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | | | | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| 29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER MEDICAL HOUSE OFFICER | | | | | | | |
| 29c. LICENSE NUMBER D43977 | | | | | | | |
| 29d. DATE SIGNED (Month, Day, Year) July 15 95 | | | | | | | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) ANDREW C. CATHWELL, NATH 301 HOSP. DRUGS, GLEN BURNIE MD 21061 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JUL 18 1995 | | | | | | | |
| 32. REGISTRAR'S SIGNATURE | | | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95-4035-510

blh

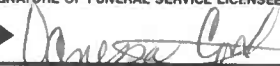


95 21645

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

| | | | | | | | | | |
|--|--|--|--|---|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) Joann Wilkerson | | | | 2. DATE OF DEATH MONTH July DAY 13 YEAR 1995 | | | | 3. TIME OF DEATH 0444 M | |
| 4. SOCIAL SECURITY NUMBER 218-60-8977 | | 5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 44 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) OCT. 13, 1950 | | 8. BIRTHPLACE (State or Foreign Country) BALTIMORE, MD | |
| 9a. FACILITY NAME (If not institution, give street and number) Johns Hopkins Hospital | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Baltimore | | | | 9c. COUNTY OF DEATH n/a | |
| 10a. STATE MARYLAND | | 10b. COUNTY n/a | | 10c. CITY, TOWN OR LOCATION BALTIMORE | | | | 10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | |
| 10e. STREET AND NUMBER 2038 ASHLAND AVENUE | | | | 10f. ZIP CODE 21205 | | 10g. CITIZEN OF WHAT COUNTRY? UNITED STATES | | | |
| 11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: BLACK | | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary <input type="checkbox"/> Secondary (9-12) <input checked="" type="checkbox"/> College (1-4 or 5+) <input type="checkbox"/> | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) unemployed | | 16b. KIND OF BUSINESS/INDUSTRY never worked | | | | | |
| 17. FATHER'S NAME (First, Middle, Last) WILLIE ADAMS | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) MATTIE CUMMINGS | | | | | |
| 19a. INFORMANT'S NAME (Type/Print) DENISE MILLER | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1103 N. PATTERSON PARK, BALTIMORE, MD 21205 | | | | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) KING MEMORIAL PARK 7-20 | | DATE 7-20 | | 20c. LOCATION — City or Town, State RANDALLSTOWN, MD | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE  | | | | 22. NAME AND ADDRESS OF FACILITY WM. C. MARCH FH.-1101 E. NORTH AVENUE | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Atherosclerotic Cardiovascular Disease DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | Approximate Interval Between Onset and Death | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. | | | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Asthma | | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | |
| 27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED | |
| 28a. PLACE OF INJURY — At home, term, street, factory, office building, etc. (Specify) | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | |
| 29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. SIGNATURE AND TITLE OF CERTIFIER  | | | | 29c. LICENSE NUMBER O.C.M.E. | | 29d. DATE SIGNED (Month, Day, Year) July 13 1995 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) THEODORE M. KING 111 Penn Street, Baltimore, Maryland 21201 | | | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JUL 18 1995 | | | | 32. REGISTRAR'S SIGNATURE  | | | | | |

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95-4137-510

b1h

95 21646

Item 22, Film 725, 7/18/95, 1t

FOR
1 - STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | | | | |
|--|--|---|--|--|--|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last) Cornell Williams | | | | 2. DATE OF DEATH MONTH DAY YEAR July 15 1995 | | 3. TIME OF DEATH 2121 M | |
| 4. SOCIAL SECURITY NUMBER 220-24-6010 | | 5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 66 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) FEB 9 1929 | |
| 9a. FACILITY NAME (If not institution, give street and number) St. Agnes Hospital | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Baltimore | | 9c. COUNTY OF DEATH N/A | |
| 10a. STATE MD | | 10b. COUNTY BALTO | | 10c. CITY, TOWN OR LOCATION BALTO | | 10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 10e. STREET AND NUMBER 3101 NORMOUNT AVE | | | | 10f. ZIP CODE 21216 | | 10g. CITIZEN OF WHAT COUNTRY? U S A | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: BLACK | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12TH College (14 or 5+) N/A | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) FORK LIFT OPERATOR | | 16b. KIND OF BUSINESS/INDUSTRY LUMBER COMPANY | | | |
| 17. FATHER'S NAME (First, Middle, Last) FRED WILLIAMS SR. | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) EVA DRAKE | | | |
| 19a. INFORMANT'S NAME (Type/Print) FRANCES AVIS WILLIAMS | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3101 NORMOUNT AVE BALTO, MD 21216 | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) ARBUTUS MEMORIAL PK 72095 | | 20c. LOCATION — City or Town, State ARBUTUS MD | | 20d. DATE 7/20/95 | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Jerome A. Thompson Jr</i> | | | | 22. NAME AND ADDRESS OF FACILITY MARCH F/H-WEST 4300 WABASH AVE | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. ARTERIO SCLEROTIC CARDIOVASCULAR DISEASE DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | | Approximate interval Between Onset and Death |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DIABETES MELLITUS | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | | | | 25. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/> |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | 29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER <i>Marlo F. Gorko Jr MD</i> | | | | 29c. LICENSE NUMBER O.C.M.E. | | 29d. DATE SIGNED (Month, Day, Year) July 16 1995 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) MARLO F. GORKO JR MD 111 Penn Street, Baltimore, Maryland 21201 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JUL 18 1995 | | | | 32. REGISTRAR'S SIGNATURE <i>Richard Marshall</i> | | | |

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 -
FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) <i>DOROTHY ETHELEEN WARD</i> | | | | 2. DATE OF DEATH MONTH DAY YEAR <i>7 16 95</i> | | 3. TIME OF DEATH HOURS MIN. <i>3:45 PM</i> | |
| 4. SOCIAL SECURITY NUMBER <i>218-260361</i> | | 5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) YRS. <i>64</i> | | 7. DATE OF BIRTH (Month, Day, Year) <i>11-27-30</i> | |
| 8. BIRTHPLACE (State or Foreign Country) <i>V.A.</i> | | | | 9a. FACILITY NAME (If not institution, give street and number) <i>Joseph Riche House</i> | | 9b. CITY, TOWN OR LOCATION OF DEATH <i>BALTO.</i> | |
| 9c. COUNTY OF DEATH <i>N/A</i> | | | | 10a. STATE <i>md.</i> | | 10b. COUNTY <i>N/A</i> | |
| 10c. CITY, TOWN OR LOCATION <i>BALTO.</i> | | | | 10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 10e. STREET AND NUMBER <i>417 E. Chase St.</i> | |
| 10f. ZIP CODE <i>21202</i> | | | | 10g. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i> | | 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | | |
| 14. RACE — American Indian, Black, White, etc. Specify: <i>Black</i> | | | | 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <i>12th</i> College (1-4 or 5+) | | | |
| 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <i>Labor</i> | | | | 16b. KIND OF BUSINESS/INDUSTRY <i>Industry</i> | | | |
| 17. FATHER'S NAME (First, Middle, Last) <i>Sharbut Royster</i> | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) <i>Inez Carrington</i> | | | |
| 19a. INFORMANT'S NAME (Type/Print) <i>Joyce Ward</i> | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>114 Summerset St BALTO. MD 21202</i> | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <i>King Men PK 7/16/95 BALTO. MD</i> | | | |
| 20c. LOCATION — City or Town, State <i>BALTO. MD</i> | | | | 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Cathleen Bitt</i> | | | |
| 22. NAME AND ADDRESS OF FACILITY <i>BETH'S Funeral Home 21213 1129 N. CHARLES ST. BALTO. MD</i> | | | | 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Respiratory arrest</i> Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST <i>Metastatic spread of carcinoma of breast</i> | | | |
| 24. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | 25. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | |
| 26. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined | | | |
| 28a. DATE OF INJURY (Month, Day, Year) | | | | 28b. TIME OF INJURY H M | | | |
| 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | 28d. DESCRIBE HOW INJURY OCCURRED | | | |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | 29b. SIGNATURE AND TITLE OF CERTIFIER <i>John W. Payne MD</i> | | | |
| 29c. LICENSE NUMBER <i>013012</i> | | | | 29d. DATE SIGNED (Month, Day, Year) <i>16 July 95</i> | | | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>John W. Payne 12565 N. Charles Street</i> | | | | 31. DATE FILED (Month, Day, Year) <i>JUL 18 1995</i> | | | |
| 32. REGISTRAR'S SIGNATURE <i>Ch. M. Riche</i> | | | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 21648

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) DORIS ROBERTS WOHNER | | | | 2. DATE OF DEATH MONTH DAY YEAR JULY 14, 1995 | | 3. TIME OF DEATH 0245 A. M | |
| 4. SOCIAL SECURITY NUMBER 215-09-8521 | | 5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 80 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 11-02-1914 | |
| 8. BIRTHPLACE (State or Foreign Country) MARYLAND | | | | 9a. FACILITY NAME (If not institution, give street and number) CHESAPEAKE MANOR NURSING HOME | | 9b. CITY, TOWN OR LOCATION OF DEATH ARNOLD | |
| 9c. COUNTY OF DEATH ANNE ARUNDEL | | | | 10a. STATE MARYLAND | | 10b. COUNTY ANNE ARUNDEL | |
| 10c. CITY, TOWN OR LOCATION GLEN BURNIE | | | | 10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 10e. STREET AND NUMBER 92 MARY LANE | |
| 10f. ZIP CODE 21061 | | | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | | 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced | |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: WHITE | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (9-12) 12 College (1-4 or 5+) N/A | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired.) DIVISION CHAIRMAN | | 16b. KIND OF BUSINESS/INDUSTRY RED CROSS | |
| 17. FATHER'S NAME (First, Middle, Last) HARRY FREDERICK SIPPEL | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) ALICE AUGUSTA ROBERTS | | | |
| 19a. INFORMANT'S NAME (Type/Print) ALICE AUGUSTA WHITAKER | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1918 BAYSIDE BEACH ROAD, PASADENA, MARYLAND 21122 | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) LOUDON PARK CEMETERY | | 20c. LOCATION — City or Town, State BALTIMORE, MD. | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Michael C. Saffian</i> | | | | 22. NAME AND ADDRESS OF FACILITY SINGLETON FUNERAL HOME 1 SECOND AVENUE, S.W. GLEN BURNIE, MARYLAND 21061 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Metastatic Carcinoma of Breast</i> Approximate Interval Between Onset and Death <i>1 Year</i> DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST a. DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Cerebrovascular Accident</i> <i>Diabetes Mellitus</i> | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | | | | |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | | | | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined | | | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER <i>Wylma M. Attending Doctor</i> | | | | 29c. LICENSE NUMBER D 21684 | | 29d. DATE SIGNED (Month, Day, Year) 7/14/95 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) C.V. CYRIAC-M.D., 1600 CRAIN HWY #106 GLEN BURNIE MD 21061 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JUL 18 1995 | | | | 32. REGISTRAR'S SIGNATURE <i>John Anderson-Rodall</i> | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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95 21649

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) MARGARET S. WALTMYER | | | | 2. DATE OF DEATH MONTH JULY DAY 12 YEAR 1995 | | 3. TIME OF DEATH 7:10 Pm M | |
| 4. SOCIAL SECURITY NUMBER 214-01-1076 | | 5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 86 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) NOV. 21, 1908 | |
| 8. BIRTHPLACE (State or Foreign Country) MD. | | | | 9a. FACILITY NAME (If not institution, give street and number) MEREDIAN PERRING PARKWAY N.H. | | 9b. CITY, TOWN OR LOCATION OF DEATH N/A | |
| 9c. COUNTY OF DEATH BALTIMORE | | | | 10a. STATE MD. | | 10b. COUNTY N/A | |
| 10c. CITY, TOWN OR LOCATION BALTIMORE | | | | 10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | 10e. STREET AND NUMBER 603 S. LAKEWOOD AVE. | |
| 10f. ZIP CODE 21224 | | | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | | 11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | | |
| 14. RACE — American Indian, Black, White, etc. Specify: WHITE | | | | 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 9 College (1-4 or 5+) College (1-4 or 5+) | | | |
| 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) HOMEMAKER | | | | 16b. KIND OF BUSINESS/INDUSTRY OWN HOME | | | |
| 17. FATHER'S NAME (First, Middle, Last) GEORGE F. SAPP | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) MARGARET TORMULLEN | | | |
| 19a. INFORMANT'S NAME (Type/Print) ELOISE DELONG | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6302 FAIRDEL AVE. BALTO. MD. 21206 | | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) 1ST UN. EVAN. CH OF CEM. 7-16-95 BALTO. MD | | | |
| 20c. LOCATION — City or Town, State BALTO. MD | | | | 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Thomas J. Skarda J. | | | |
| 22. NAME AND ADDRESS OF FACILITY SKARDA F.H. 2029 HUDSON ST. BALTO., MD. 21224 | | | | 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Myocardial infarction Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Acute myocardial infarction | | | | 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | |
| 27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide | | | | 28a. DATE OF INJURY (Month, Day, Year) 7/14/95 | | | |
| 28b. TIME OF INJURY M | | | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | 29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER Dr. Patricia | | | | 29c. LICENSE NUMBER D08358 | | | |
| 29d. DATE SIGNED (Month, Day, Year) 7/14/95 | | | | 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) GRACIE K. PATRICIA 8903 HARTFORD ROAD BALTO. MD 21093 | | | |
| 31. DATE FILED (Month, Day, Year) JUL 18 1995 | | | | 32. REGISTRAR'S SIGNATURE Jehi Anderson-Rodell | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 21650

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) Luise Wilhelmine Wuechner | | | | 2. DATE OF DEATH MONTH July DAY 14 YEAR 1995 | | 3. TIME OF DEATH 10:30 Pm | |
| 4. SOCIAL SECURITY NUMBER 215-40-9198 | | 5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 88 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) July 12, 1907 | |
| 9a. FACILITY NAME (If not institution, give street and number) Meridian Nursing Home | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Parkville | | 9c. COUNTY OF DEATH Baltimore | |
| RESIDENCE OF DECEDENT | | | | | | | |
| 10a. STATE Maryland | | 10b. COUNTY Baltimore | | 10c. CITY, TOWN OR LOCATION Parkville | | 10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 10e. STREET AND NUMBER 1801 Wentworth Road | | | | 10f. ZIP CODE 21234 | | 10g. CITIZEN OF WHAT COUNTRY? Germany | |
| 11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) 12 | | 15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Homemaker | | 16b. KIND OF BUSINESS/INDUSTRY Home | | | |
| 17. FATHER'S NAME (First, Middle, Last) Heinrich Haussler | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Wilhelmine Schroeder | | | |
| 19a. INFORMANT'S NAME (Type/Print) Hedi Drummond | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 600 Squire Ln., Apt. 2E Bel Air, MD 21014 | | | |
| 20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Metro Crematory, Inc. 7/15/95 | | 20c. LOCATION — City or Town, State Baltimore, MD | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE George E. MacNabb | | | | 22. NAME AND ADDRESS OF FACILITY Cremation Society of Md., Inc. 299 Frederick Rd. Balto., MD 21228 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Acute CVA Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. Acute CVA DUE TO (OR AS A CONSEQUENCE OF): b. Arterio-sclerotic Cerebrovascular Disease DUE TO (OR AS A CONSEQUENCE OF): c. Disease DUE TO (OR AS A CONSEQUENCE OF): d. | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Pneumonia | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER Dr. Patricia | | | | 29c. LICENSE NUMBER 008358 | | 29d. DATE SIGNED (Month, Day, Year) July 15, 1995 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) SPACity V. PATRICIO 8903 HARTWOOD ROAD BACT. 10821093 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JUL 18 1995 | | REGISTRAR'S SIGNATURE John Anderson | | | | | |

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

95 21651

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) MARY E. WISNER | | | | 2. DATE OF DEATH MONTH DAY YEAR July 16, 1995 | | 3. TIME OF DEATH 7:30 pm M | |
| 4. SOCIAL SECURITY NUMBER 220-07-8775 | | 5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 78 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) May 2, 1917 | |
| 9a. FACILITY NAME (If not institution, give street and number) Liberty Medical Center | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Baltimore, | | 9c. COUNTY OF DEATH N/A | |
| RESIDENCE OF DECEDENT | | | | | | | |
| 10a. STATE Maryland | | 10b. COUNTY N/A | | 10c. CITY, TOWN OR LOCATION Baltimore | | 10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 10e. STREET AND NUMBER 841 West 34th Street | | | | 10f. ZIP CODE 21211 | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 8th College (1-4 or 5+) | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Housewife | | 16b. KIND OF BUSINESS/INDUSTRY Own home | | | |
| 17. FATHER'S NAME (First, Middle, Last) unk | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) unk | | | |
| 19a. INFORMANT'S NAME (Type/Print) Jerry Wisner | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 841 West 34th Street, Baltimore, Md 21211 | | | |
| 20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Green Mount Cem 7/20 | | 20c. LOCATION — City or Town, State Baltimore, Md | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE A. Alan Seitz, Jr. | | | | 22. NAME AND ADDRESS OF FACILITY A. Alan Seitz, Jr. Funeral Home 3818 Roland Avenue, Baltimore, Md 21211 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <u>Emphysema</u> DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | | Approximate Interval Between Onset and Death 10 yr |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>Coronary Artery Disease</u> | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DDA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| | | 28d. DESCRIBE HOW INJURY OCCURRED | | | | 28e. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER Richard Oran | | | | 29c. LICENSE NUMBER D23076 | | 29d. DATE SIGNED (Month, Day, Year) 7-18-95 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) SICHA ARD DIARYMD 3730 Falls Rd Balt Md 21211 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JUL 18 1995 | | | | 32. REGISTRAR'S SIGNATURE John Andrew Karbott | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|---|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) Minnie Williams | | | | 2. DATE OF DEATH MONTH July DAY 9 YEAR 1995 | | 3. TIME OF DEATH 9:09 AM | |
| 4. SOCIAL SECURITY NUMBER 579-22-7335 | | 5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F | 6. AGE (In yrs. last birthday) 73 YRS. | IF UNDER 1 YEAR MONTHS 0 DAYS 0 | IF UNDER 24 HRS. HOURS 0 MIN. 0 | 7. DATE OF BIRTH (Month, Day, Year) 8-15-21 | |
| 9a. FACILITY NAME (If not institution, give street and number) Grosvenor Health Care Center | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Bethesda | | 9c. COUNTY OF DEATH Montgomery | |
| 10a. STATE Maryland | | | | 10b. COUNTY Bethesda | | 10c. CITY, TOWN OR LOCATION Bethesda | |
| 10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input type="checkbox"/> NO | | | | 10e. STREET AND NUMBER 5721 Grosvenor Lane | | | |
| 10f. ZIP CODE 20814 | | | | 10g. CITIZEN OF WHAT COUNTRY? | | | |
| 11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: Black | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) | | 16b. KIND OF BUSINESS/INDUSTRY | | | |
| 17. FATHER'S NAME (First, Middle, Last) | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) | | | |
| 19a. INFORMANT'S NAME (Type/Print) | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) | | | |
| 20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input checked="" type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) in state removal | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) | | DATE | | 20c. LOCATION — City or Town, State | |
| 21. SIGNATURE OF ADOPTED SERVICE LICENSEE Ronald Wade, Dir. | | 22. NAME AND ADDRESS OF FACILITY State Anatomy Board 655 W. Baltimore St., Baltimore, MD. 21201 | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Cordless Constriction | | | | | | | |
| DUE TO (OR AS A CONSEQUENCE OF): b. Unknown | | | | | | | |
| DUE TO (OR AS A CONSEQUENCE OF): c. | | | | | | | |
| DUE TO (OR AS A CONSEQUENCE OF): d. | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | | | | |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO | | | | | | | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA <input checked="" type="checkbox"/> OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER [Signature] M.D. | | | | 29c. LICENSE NUMBER 020516 | | 29d. DATE SIGNED (Month, Day, Year) 7/9/95 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 19410 Old Georgetown Rd Bethesda MD 20814 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JUL 17 1995 | | 32. REGISTRAR'S SIGNATURE [Signature] | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Released by Medical Examiner - Dr. Tauber

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) Erbie Norrell | | | | 2. DATE OF DEATH MONTH 07 DAY 10 YEAR 95 | | 3. TIME OF DEATH 6:15 PM M | |
| 4. SOCIAL SECURITY NUMBER 168-14-2450 | | 5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 79 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 1-13-16 | |
| 8a. FACILITY NAME (If not Institution, give street and number) Johns Hopkins Bayview Med Center | | | | 8b. CITY, TOWN OR LOCATION OF DEATH Baltimore | | 8c. COUNTY OF DEATH Baltimore | |
| 9. RESIDENCE OF DECEDENT | | | | 10a. STATE MD | | 10b. COUNTY | |
| 10c. CITY, TOWN OR LOCATION Baltimore | | | | 10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | | |
| 10e. STREET AND NUMBER Northpoint 1046 Old Northpoint Road | | | | 10f. ZIP CODE 21224 | | 10g. CITIZEN OF WHAT COUNTRY? | |
| 11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4 or 5+) <input type="checkbox"/> | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) | | 16b. KIND OF BUSINESS/INDUSTRY | | | |
| 17. FATHER'S NAME (First, Middle, Last) | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) | | | |
| 19a. INFORMANT'S NAME (Type/Print) | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) | | | |
| 20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input checked="" type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) in state removal | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) | | DATE | | 20c. LOCATION — City or Town, State | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Ronald Wade, Dir. | | 22. NAME AND ADDRESS OF FACILITY State Anatomy Board 655 W. Baltimore Street, Balto., MD. 21201 | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Apnea DUE TO (OR AS A CONSEQUENCE OF): Respiratory insufficiency DUE TO (OR AS A CONSEQUENCE OF): Hypercarbia DUE TO (OR AS A CONSEQUENCE OF): COPD and R lung infiltrate | | | | | | | Approximate Interval Between Onset and Death 1 hour 15 min 1 hour 15 min 1 hour 15 min |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | | | | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | | | 28e. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER MD | | | | 29c. LICENSE NUMBER 96010 | | 29d. DATE SIGNED (Month, Day, Year) 7/10/95 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Pana Johns Hopkins Bayview Medical Center | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JUL 17 1995 | | 32. REGISTRAR'S SIGNATURE Ronald Wade | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 21654

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | |
|---|--|--|--|---|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) Dolores WIESNER | | | | 2. DATE OF DEATH MONTH July DAY 15 YEAR 1995 | | | | 3. TIME OF DEATH 10:24 A. M. | |
| 4. SOCIAL SECURITY NUMBER 220-18-6598 | | 5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 67 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) Jan. 4, 1928 | | 8. BIRTHPLACE (State or Foreign Country) Maryland | |
| 9a. FACILITY NAME (If not institution, give street and number) Franklin Square Hospital | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Rossville | | | | 9c. COUNTY OF DEATH Baltimore County | |
| 10a. STATE Maryland | | 10b. COUNTY Baltimore County | | 10c. CITY, TOWN OR LOCATION Baltimore | | | | 10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 10e. STREET AND NUMBER 22 Sipple Avenue | | | | 10f. ZIP CODE 21236 | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | | | |
| 11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White | | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12th Grade College (1-4 or 5+) | | 15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Bookkeeper | | 15b. KIND OF BUSINESS/INDUSTRY Insurance Agency | | | | | |
| 17. FATHER'S NAME (First, Middle, Last) Anthony Unknown | | | | 16. MOTHER'S NAME (First, Middle, Maiden Surname) Evelyn Unknown Twilley | | | | | |
| 19a. INFORMANT'S NAME (Type/Print) Richard Anthony Wiesner | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1228 Narcissus Avenue, Baltimore, Maryland 21237 | | | | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Parkwood Cemetery 7/19/95 | | 20c. LOCATION — City or Town, State Baltimore, Maryland | | | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Kathleen M. Murphy</i> | | | | 22. NAME AND ADDRESS OF FACILITY John C. Miller, Inc. 6415 Belair Road, Baltimore, Maryland 21206 | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Carcinoma of the Pancreas with metastasis DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | | | Approximate interval Between Onset and Death 2 months | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED | |
| 28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28i. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i> 0146 | | 29c. LICENSE NUMBER R.D. 1922 | | 29d. DATE SIGNED (Month, Day, Year) July 15, 1995 | | | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) J.S. Rana, MD 9000 Franklin Square Drive Baltimore MD. 21237 | | | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JUL 18 1995 | | 32. REGISTRAR'S SIGNATURE <i>[Signature]</i> | | | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 21655

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|--|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) JOHN WRIGHT | | | | 2. DATE OF DEATH MONTH JULY DAY 10 YEAR 1995 | | 3. TIME OF DEATH 4.08 P M | |
| 4. SOCIAL SECURITY NUMBER | | 5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F | 6. AGE (In yrs. last birthday) 36 YRS. | 7. DATE OF BIRTH (Month, Day, Year) 1-01-59 | | 8. BIRTHPLACE (State or Foreign Country) | |
| 9a. FACILITY NAME (If not institution, give street and number) UNION MEMORIAL HOSPITAL | | | | 9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE CITY | | 9c. COUNTY OF DEATH | |
| RESIDENCE OF DECEDENT | | | | | | | |
| 10a. STATE Maryland | | 10b. COUNTY | | 10c. CITY, TOWN OR LOCATION Baltimore | | 10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input type="checkbox"/> NO | |
| 10e. STREET AND NUMBER 3432 Belair Road | | | | 10f. ZIP CODE 21213 | | 10g. CITIZEN OF WHAT COUNTRY? | |
| 11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: Black | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4 or 5+) <input type="checkbox"/> | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. DO NOT use retired.) | | 16b. KIND OF BUSINESS/INDUSTRY | |
| 17. FATHER'S NAME (First, Middle, Last) | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) | | | |
| 19a. INFORMANT'S NAME (Type/Print) | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) | | | |
| 20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) | | DATE | | 20c. LOCATION — City or Town, State | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Ronald Wade, Dir. | | | | 22. NAME AND ADDRESS OF FACILITY State Anatomy Board 655 W. Baltimore St., Baltimore, MD. 21201 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → End stage AIDS Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST a. Brain Toxoplasmosis b. Pancytopenia c. PCP d. PCP | | | | | | | Approximate interval Between Onset and Death years 2 wks 1 wks 3 wks |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input type="checkbox"/> NO |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/> | | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO | |
| 28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28d. DESCRIBE HOW INJURY OCCURRED | | | |
| 28e. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER Zaiqi Wang, MD | | | | 29c. LICENSE NUMBER AT2438946 | | 29d. DATE SIGNED (Month, Day, Year) July 10, 1995 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) ZAIQI WANG, The Union Memorial Hospital, Baltimore | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JUL 17 1995 | | | | 32. REGISTRAR'S SIGNATURE [Signature] | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 21656

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) John Norman Yonker | | | | 2. DATE OF DEATH MONTH DAY YEAR JULY 16 1995 | | 3. TIME OF DEATH 11:44 A M | |
| 4. SOCIAL SECURITY NUMBER 145-22-9693 | | 5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 65 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) JULY 22, 1929 | |
| 8. BIRTHPLACE (State or Foreign Country) New Jersey | | | | 9a. FACILITY NAME (If not institution, give street and number) 1100 Joh Avenue | | 9b. CITY, TOWN OR LOCATION OF DEATH Baltimore | |
| 9c. COUNTY OF DEATH N/A | | | | 10a. STATE Maryland | | 10b. COUNTY N/A | |
| 10c. CITY, TOWN OR LOCATION Baltimore | | | | 10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | 10e. STREET AND NUMBER 1100 Joh Avenue | |
| 10f. ZIP CODE 21229 | | | | 10g. CITIZEN OF WHAT COUNTRY? USA | | 11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES 1948-1968 | | | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (8-12) 12 College (1-4 or 5+) 4 | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Electronic Equip. Repair | | 16b. KIND OF BUSINESS/INDUSTRY N.S.A. | |
| 17. FATHER'S NAME (First, Middle, Last) George M. Yonker | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Edna Magher | | | |
| 19a. INFORMANT'S NAME (Type/Print) Helen P. Yonker | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1100 Joh Ave. Baltimore, MD 21229 | | | |
| 20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Metro Crematory, Inc. 07/17/95 | | 20c. LOCATION — City or Town, State Baltimore, MD | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Hilary J. Stallings | | | | 22. NAME AND ADDRESS OF FACILITY Cremation Society of Maryland, Inc. 299 Frederick Rd. Baltimore, MD 21228 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. METASTATIC COLOID CARCINOMA DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): Approximate Interval Between Onset and Death 10 mos | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | | | | |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO | | | | | | | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 28d. DESCRIBE NOW INJURY OCCURRED | | | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | 28g. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER Diane H. Griffiths, M.D. | | | | 29c. LICENSE NUMBER D19419 | | 29d. DATE SIGNED (Month, Day, Year) July 17, 1995 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Diane H. Griffiths, M.D., 900 S. Caton Ave., Baltimore, MD 21229 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JUL 18 1995 | | | | 32. REGISTRAR'S SIGNATURE Julia Shuckman-Randall | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 21657

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) Isabelle Abrams | | | | 2. DATE OF DEATH MONTH July DAY 07 YEAR 1995 | | 3. TIME OF DEATH 4 20 P M | |
| 4. SOCIAL SECURITY NUMBER 066-14-4880 | | 5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 8. AGE (In yrs. last birthday) 80 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) MAY 17, 1915 | |
| 9a. FACILITY NAME (If not institution, give street and number) Good Samaritan | | 9b. CITY, TOWN OR LOCATION OF DEATH Baltimore | | | | 9c. COUNTY OF DEATH — | |
| RESIDENCE OF DECEDENT | | | | | | | |
| 10a. STATE Md. | | 10b. COUNTY Baltimore | | 10c. CITY, TOWN OR LOCATION Towson | | 10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 10e. STREET AND NUMBER 28 DUNVALE Rd. | | | | 10f. ZIP CODE 21204 | | 10g. CITIZEN OF WHAT COUNTRY? USA | |
| 11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: WHITE | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 6 College (1-4 or 5+) — | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Homemaker | | 16b. KIND OF BUSINESS/INDUSTRY Home | | | |
| 17. FATHER'S NAME (First, Middle, Last) UNKNOWN | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) UNKNOWN SMITH | | | |
| 19a. INFORMANT'S NAME (Type/Print) Jean Von OEHSEN | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 87-18 87th Street Woodhaven N.Y. 11421 | | | |
| 20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Green Mount Cemetery | | DATE 7/14/95 | | 20c. LOCATION — City or Town, State Baltimore, Md | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Robert W. Green | | | | 22. NAME AND ADDRESS OF FACILITY Evens Chapel & Memories 8800 HARFORD Rd. Balto. Md 21234 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | | a. Arrhythmia DUE TO (OR AS A CONSEQUENCE OF): | | | | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | b. Myocardial Infarction DUE TO (OR AS A CONSEQUENCE OF): | | | | | |
| | | c. Cerebral Artery Disease DUE TO (OR AS A CONSEQUENCE OF): | | | | | |
| | | d. | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Dementia OSTEO ARTHROSIS | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO | | | | | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/> | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO | |
| | | 28d. DESCRIBE HOW INJURY OCCURRED | | | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | |
| | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | |
| 29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER DR Simon SCALIA | | | | 29c. LICENSE NUMBER 024226 | | 29d. DATE SIGNED (Month, Day, Year) 7.13.95 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) DR Simon SCALIA 5601 Loch Raven BLVD. | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JUL 19 1995 | | | | 32. REGISTRAR'S SIGNATURE John Andrew Randall | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 21658

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|---|--|---|--|--|---|
| 1. DECEDENT'S NAME (First, Middle, Last) Viola Hart Arrington | | | | 2. DATE OF DEATH MONTH DAY YEAR July 16 1995 | | 3. TIME OF DEATH 8:02a M | |
| 4. SOCIAL SECURITY NUMBER 241-62-7014 | | 5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 85 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 10-23-09 | |
| 8. BIRTHPLACE (State or Foreign Country) N.C. | | | | 9a. FACILITY NAME (If not institution, give street and number) 4103 W. Forest Park Ave. | | 9b. CITY, TOWN OR LOCATION OF DEATH Baltimore | |
| 9c. COUNTY OF DEATH n/a | | | | 10a. STATE MD | | 10b. COUNTY n/a | |
| 10c. CITY, TOWN OR LOCATION Baltimore | | | | 10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 10e. STREET AND NUMBER 4103 W. Forest Park Ave. | |
| 10f. ZIP CODE 21207 | | | | 10g. CITIZEN OF WHAT COUNTRY? USA | | 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: Black | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5 +) 10th | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Housewife | | 16b. KIND OF BUSINESS/INDUSTRY Domestic | |
| 17. FATHER'S NAME (First, Middle, Last) Robert Hart | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Leah Coley | | | |
| 19a. INFORMANT'S NAME (Type/Print) Joe Arrington | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4102 Oakford Ave. Balto., MD 21215 | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) King Memorial Park 7/21 | | 20c. LOCATION — City or Town, State Randallstown, MD | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>James A. Morton</i> | | | | 22. NAME AND ADDRESS OF FACILITY James A. Morton & Sons Funeral Home 1701 Laurens St. Balto., MD 21217 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. myocardial INFarction b. alzheimer's Disease c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | | Approximate Interval Between Onset and Death 6 years |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | | | | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, term, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER Terance L. Lamb MD | | | | 29c. LICENSE NUMBER D37203 | | 29d. DATE SIGNED (Month, Day, Year) July 18th 1995 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Terance L. Lamb Liberty Medical Center, Baltimore, MD 21215 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JUL 19 1995 | | | | 32. REGISTRAR'S SIGNATURE <i>John A. Riddell</i> | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

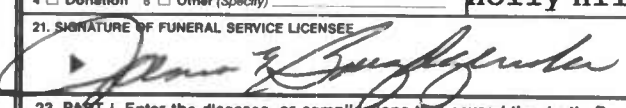
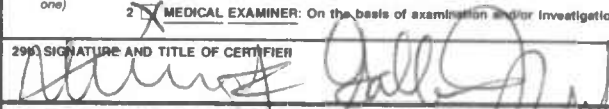
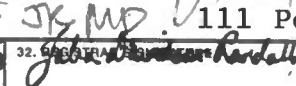
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1964

UNKNOWN 95-168
STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1 - FOR
STATE
REGISTRAR

REG. NO.

| | | | | | | | |
|--|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) WILLIAM G ALLEN | | | | 2. DATE OF DEATH MONTH 07 DAY 14 YEAR 1995 | | 3. TIME OF DEATH 01:30 A M | |
| 4. SOCIAL SECURITY NUMBER 213-60-0961 | | 5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 43 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) March 24, 1952 | |
| 8. BIRTHPLACE (State or Foreign Country) Maryland | | | | 9a. FACILITY NAME (If not institution, give street and number) EASTERN AVE. & MYERS VIEW ROAD | | 9b. CITY, TOWN OR LOCATION OF DEATH Middle River | |
| 9c. COUNTY OF DEATH BALTIMORE | | | | 10a. STATE Maryland | | 10b. COUNTY Baltimore | |
| 10c. CITY, TOWN OR LOCATION Middle River | | | | 10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 10e. STREET AND NUMBER 7421 Gun Powder Rd. | |
| 10f. ZIP CODE 21220 | | | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | | | |
| 11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (9-12) 12 College (1-4 or 5+) | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Laborer | | 16b. KIND OF BUSINESS/INDUSTRY Steel Mill | |
| 17. FATHER'S NAME (First, Middle, Last) William G. Allen | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Donna House | | | |
| 19a. INFORMANT'S NAME (Type/Print) Marlene E. Allen | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7421 Gun Powder Rd. Baltimore, MD. 21220 | | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematorium, or other place) Holly Hill Mem. Gardens 7/17/1995 Baltimore, MD. | | 20c. LOCATION — City or Town, State | | 20d. DATE | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE  | | | | 22. NAME AND ADDRESS OF FACILITY Bruzdinski Funeral Home P.A. 1407 Old Eastern Ave. Balt. MD. 21221 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → MULTIPLE INJURIES DUE TO (OR AS A CONSEQUENCE OF): Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) SCENE | | | | | |
| 27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) 7/14/95 | | 28b. TIME OF INJURY 0105A M | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) STREET | | 28e. DESCRIBE HOW INJURY OCCURRED DRIVER OF TRUCK VS FIXED OBJECT COLLISION | | | | | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) BALTIMORE COUNTY EASTERN AVE & MYERS BLVD MD | | 29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER  | | | | 29c. LICENSE NUMBER O.C.M.E. | | 29d. DATE SIGNED (Month, Day, Year) 07 14 1995 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (Item 27) (Type, Print) MARIO F. GOULET JR. MD. 111 Penn Street, Baltimore, Maryland 21201 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JUL 19 1995 | | | | 32. SIGNATURE OF REGISTRAR  | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95-4113-510

blh

95 21660

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

| | | | | | | | |
|---|--|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) Thomas E Anderson | | | | 2. DATE OF DEATH MONTH July DAY 14 YEAR 1995 | | 3. TIME OF DEATH 2248 M | |
| 4. SOCIAL SECURITY NUMBER 189-44-8594 | | 5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 8. AGE (In yrs. last birthday) 42 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) Aug. 15, 1952 | |
| 9a. FACILITY NAME (If not institution, give street and number) Good Samaritan Hospital | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Baltimore | | 9c. COUNTY OF DEATH N/A | |
| 10a. STATE Maryland | | | | 10b. COUNTY -- | | 10c. CITY, TOWN OR LOCATION Baltimore | |
| 10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | | | 10e. STREET AND NUMBER 3011 Kenyon Avenue | | | |
| 10f. ZIP CODE 21213 | | | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | | | |
| 11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 4 College (1-4 or 5+) 4 | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Dispatcher | | 16b. KIND OF BUSINESS/INDUSTRY Maritime Shipping | | | |
| 17. FATHER'S NAME (First, Middle, Last) Donald C. Anderson | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Mary Jehu | | | |
| 19a. INFORMANT'S NAME (Type/Print) Donald C. Anderson | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 153 Toledo Way Rock Ledge, Florida 32955 | | | |
| 20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Greenmount Crematory 7/18/95 | | 20c. LOCATION — City or Town, State Baltimore, MD. | | 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | |
| 22. NAME AND ADDRESS OF FACILITY Brudzinski Funeral Home P.A. | | 1407 Old Eastern Ave. Balt., MD. 21221 | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → ASTHMA a. DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | | | | | | |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO | | | | | | | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/> | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO | |
| 28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28d. DESCRIBE HOW INJURY OCCURRED | | | | | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | 29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER | | 29c. LICENSE NUMBER O.C.M.E. | | 29d. DATE SIGNED (Month, Day, Year) July 15 1995 | | | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) MARIO F. GOLIE JR MD, 111 Penn Street, Baltimore, Maryland 21201 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JUL 19 1995 | | 32. COUNTY REGISTRAR'S SIGNATURE | | | | | |

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 21661

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|--|--|---|--|--|---|
| 1. DECEDENT'S NAME (First, Middle, Last) Charles K. BRAMBLE | | | | 2. DATE OF DEATH MONTH DAY YEAR July 17 1995 | | 3. TIME OF DEATH 6:40 A M | |
| 4. SOCIAL SECURITY NUMBER 218-03-3467 | | 5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 75 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) Jan 21 1920 | |
| 8. BIRTHPLACE (State or Foreign Country) Maryland | | 9a. FACILITY NAME (If not institution, give street and number) Summit Nursing Home | | 9b. CITY, TOWN OR LOCATION OF DEATH Catonsville | | 9c. COUNTY OF DEATH Baltimore | |
| 10a. STATE Maryland | | | | 10b. COUNTY Baltimore | | 10c. CITY, TOWN OR LOCATION Baltimore | |
| 10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | | | | |
| 10e. STREET AND NUMBER 3 Marathon Ct., Apt 2A | | | | 10f. ZIP CODE 21228 | | 10g. CITIZEN OF WHAT COUNTRY? USA | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES WWII | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 12 | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Model Maker | | 16b. KIND OF BUSINESS/INDUSTRY Westinghouse | | | |
| 17. FATHER'S NAME (First, Middle, Last) Charles M. BRAMBLE | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Pauline FLOYD | | | |
| 19a. INFORMANT'S NAME (Type/Print) Mary G. Bramble | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3 Marathon Ct, Apt 2A Baltimore, MD 21228 | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Meadowridge Memorial Park 7/20 | | 20c. LOCATION — City or Town, State Elkridge, MD | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE M. Neal Coleman | | | | 22. NAME AND ADDRESS OF FACILITY HUBBARD FUNERAL HOME, INC. 4107 Wilkens Avenue, Baltimore, MD 21229 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Sudden Death DUE TO (OR AS A CONSEQUENCE OF): b. Hypertension DUE TO (OR AS A CONSEQUENCE OF): c. _____ DUE TO (OR AS A CONSEQUENCE OF): d. _____ Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | | Approximate interval Between Onset and Death 10 yrs |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Cholelithiasis & Arteriosclerosis Heart Failure | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | | | | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28b. DESCRIBE HOW INJURY OCCURRED | | 28c. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER Dr. David Moseman | | | | 29c. LICENSE NUMBER D19821 | | 29d. DATE SIGNED (Month, Day, Year) 7-17-95 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Dr. David Moseman 5205 East Drive, Suite N, Baltimore, MD 21227 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JUL 19 1995 | | | | 32. REGISTRAR'S SIGNATURE John D. Henderson | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Item 7, g-726, 8-2-95, perf. h., dk

Item 1, g-725, 7-19-95, perf. h., dk

95 21662

FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | | | | | |
|--|--|--|--|--|--|--|--|---|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) VIRGINIA LEE BAESCH | | | | 2. DATE OF DEATH MONTH 07 DAY 11 YEAR 95 | | | | 3. TIME OF DEATH 730 AM | | | | | |
| 4. SOCIAL SECURITY NUMBER 216-07-8271 | | | | 5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 84 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) July 15, 1910 | | 8. BIRTHPLACE (State or Foreign Country) Maryland | | | |
| 9a. FACILITY NAME (If not institution, give street and number) Maryland Manor Conv. | | | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Glen Burnie | | | | 9c. COUNTY OF DEATH ANNE ARUNDEL | | | |
| 10a. STATE Md | | | | 10b. COUNTY Balto. | | | | 10c. CITY, TOWN OR LOCATION PARKVILLE | | | | 10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| 10e. STREET AND NUMBER 8723 Stockwell Rd | | | | | | 10f. ZIP CODE 21234 | | | | 10g. CITIZEN OF WHAT COUNTRY? USA | | | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | | | 14. RACE — American Indian, Black, White, etc. Specify: WHITE | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 9 College (1-4 or 5+) — | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Housewife | | | | 16b. KIND OF BUSINESS/INDUSTRY Home | | | | | |
| 17. FATHER'S NAME (First, Middle, Last) WILLIAM F. KANZLER | | | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Sadie S. McELWEE | | | | | | | |
| 19a. INFORMANT'S NAME (Type/Print) DAWN STRUMSKY | | | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 294 CHALET DR. Millersville, Md. 21108 | | | | | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) CEDAR HILL Cem. 7/15/95 | | | | 20c. LOCATION — City or Town, State Glen Burnie, Md. | | | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i> | | | | | | 22. NAME AND ADDRESS OF FACILITY EVANS CHAPEL of Memories 8800 HARFORD Rd. Balto. Md. 21234 | | | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. CONGESTIVE HEART FAILURE 2 years ESSENTIAL HYPERTENSION 15 years OLD CEREBROVASCULAR ACCIDENT 3 months MULTIPLE DECUBIT II 2 months | | | | | | | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. PERIPHERAL VASCULAR DISEASE CHRONIC RENAL FAILURE | | | | | | | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | 28. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED | | | |
| | | | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i> MD. Physician | | | | | | 29c. LICENSE NUMBER D14160 | | 29d. DATE SIGNED (Month, Day, Year) 07/11/95 | | | | | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 2) (Type, Print) HARJIT SINGH M.D. 5410-A RITCHIE HWY, BALTIMORE, Md. - 21225 | | | | | | | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JUL 19 1995 | | | | 32. REGISTRAR'S SIGNATURE <i>[Signature]</i> | | | | | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020
 TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the attending physician or attending physician.
 TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be returned to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
 IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified.

95 21663

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|---|--|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last) ALEXANDER BRUNO BARRON | | | | 2. DATE OF DEATH MONTH DAY YEAR July 16, 1995 | | 3. TIME OF DEATH 1:16 P. | |
| 4. SOCIAL SECURITY NUMBER 214 01 5457 | | 5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 79 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 02 15 16 | |
| 9a. FACILITY NAME (If not institution, give street and number) Bay View Medical Center | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Baltimore | | 9c. COUNTY OF DEATH N/A | |
| RESIDENCE OF DECEDENT | | | | | | | |
| 10a. STATE Md. | | 10b. COUNTY N/A | | 10c. CITY, TOWN OR LOCATION Baltimore | | 10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | |
| 10e. STREET AND NUMBER 629 South Decker Avenue | | | | 10f. ZIP CODE 21224 | | 10g. CITIZEN OF WHAT COUNTRY? USA | |
| 11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 10 College (1-4 or 5+) | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Inspector | | 16b. KIND OF BUSINESS/INDUSTRY Crown, Cork, Seal | | | |
| 17. FATHER'S NAME (First, Middle, Last) Jopseph Barron | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Marie Frank | | | |
| 19a. INFORMANT'S NAME (Type/Print) Warren E. Barron | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 208 Arabian Court Gambrills, Md. 21054 | | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Most Holy Redeemer Cem. 7-19-95 | | 20c. LOCATION — City or Town, State Baltimore, Md. | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Charles D. Zeiler</i> | | | | 22. NAME AND ADDRESS OF FACILITY Charles S. Zeiler & Son Inc. 901 S. Conkling St. Balto., Md. | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Cardiopulmonary Arrest Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST a. DUE TO (OR AS A CONSEQUENCE OF): Coronary Artery Disease b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. | | | | | | | Approximate Interval Between Onset and Death |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO | | | | | | | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO | |
| | | 28d. PLACE OF INJURY — At home, term, street, tectory, office building, etc. (Specify) | | 28e. DESCRIBE HOW INJURY OCCURRED | | | |
| | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER <i>Sandra M. MD</i> | | | | 29c. LICENSE NUMBER 95011 | | 29d. DATE SIGNED (Month, Day, Year) 7/17/95 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 4940 Eastern Ave, Baltimore, MD. | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JUL 19 1995 | | | | 32. REGISTRAR'S SIGNATURE <i>Johanna D. ...</i> | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 21664

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|---|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) Gertrude Marie Blackwell GERTRUDE BLACKWELL | | | | 2. DATE OF DEATH MONTH JULY DAY 15 YEAR 95 | | 3. TIME OF DEATH 0540 AM | |
| 4. SOCIAL SECURITY NUMBER 212-18-3615 | | 5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 93 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) FEB 28, 1902 | |
| 8. BIRTHPLACE (State or Foreign Country) N. Carolina | | | | 9. FACILITY NAME (If not institution, give street and number) Northwest Medical Center | | 10. CITY, TOWN OR LOCATION OF DEATH Randallstown | |
| 11. RESIDENCE OF DECEDENT | | | | 12. COUNTY OF DEATH N/A | | 13. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 14. STATE Maryland | | 15. COUNTY N/A | | 16. CITY, TOWN OR LOCATION Baltimore | | 17. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 18. STREET AND NUMBER 3713 GIBBONS AVENUE | | | | 19. ZIP CODE 21206 | | 20. CITIZEN OF WHAT COUNTRY? USA | |
| 21. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 22. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 23. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 24. RACE — American Indian, Black, White, etc. Specify: Black | |
| 25. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 10th grade | | 26. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Housewife | | 27. KIND OF BUSINESS/INDUSTRY Own Home | | 28. DECEDENT'S FATHER'S NAME (First, Middle, Last) Singer Caldwell | |
| 29. DECEDENT'S MOTHER'S NAME (First, Middle, Maiden Surname) Cora Powell | | 30. INFORMANT'S NAME (Type/Print) Isaac Mitchell | | 31. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3713 Gibbons Avenue Baltimore Maryland 21206 | | 32. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | |
| 33. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Western Star Cemetery 7/2/95 Catonsville, Maryland | | 34. SIGNATURE OF FUNERAL SERVICE LICENSEE Gray Harris | | 35. NAME AND ADDRESS OF FACILITY CHAMPION-HARRIS F.H. Baltimore, Md 21201 | | 36. PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | |
| 37. IMMEDIATE CAUSE (Final disease or condition resulting in death) → SEPSIS | | 38. DUE TO (OR AS A CONSEQUENCE OF): MULTIPLE DECUBITOUS ULCERS | | 39. DUE TO (OR AS A CONSEQUENCE OF): OSTEOMYELITIS | | 40. DUE TO (OR AS A CONSEQUENCE OF): | |
| 41. SEQUENTIALLY list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | 42. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | 43. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 44. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| 45. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 46. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | 47. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | 48. DATE OF INJURY (Month, Day, Year) 7/15/95 | |
| 49. TIME OF INJURY M | | 50. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 51. DESCRIBE HOW INJURY OCCURRED | | 52. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |
| 53. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 54. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 55. SIGNATURE AND TITLE OF CERTIFIER AGBOGY B | | 56. LICENSE NUMBER D45045 | |
| 57. DATE SIGNED (Month, Day, Year) 7/15/95 | | 58. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) AGBOGY B NORTHWEST HOSP BALTO MD | | 59. DATE FILED (Month, Day, Year) JUL 19 1995 | | 60. REGISTRAR'S SIGNATURE John Davidson Randall | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 5 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) <i>Mary Amelia Brown</i> | | | | 2. DATE OF DEATH MONTH <i>July</i> DAY <i>15</i> YEAR <i>1995</i> | | 3. TIME OF DEATH <i>12:48 P.M.</i> | |
| 4. SOCIAL SECURITY NUMBER <i>272-20-3629</i> | | 5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) <i>81</i> YRS. | | 7. DATE OF BIRTH (Month, Day, Year) <i>May 19, 1914</i> | |
| 8. BIRTHPLACE (State or Foreign Country) <i>Maryland</i> | | | | 9a. FACILITY NAME (If not institution, give street and number) <i>Meridian Heritage Nursing Center</i> | | 9b. CITY, TOWN OR LOCATION OF DEATH <i>Dundalk</i> | |
| 9c. COUNTY OF DEATH <i>Baltimore</i> | | | | 10a. STATE <i>Maryland</i> | | 10b. COUNTY <i>Baltimore</i> | |
| 10c. CITY, TOWN OR LOCATION <i>Essex</i> | | | | 10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 10e. STREET AND NUMBER <i>502 Dorsey Road</i> | |
| 10f. ZIP CODE <i>21221</i> | | | | 10g. CITIZEN OF WHAT COUNTRY? <i>United States</i> | | 11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | | |
| 14. RACE — American Indian, Black, White, etc. Specify: <i>White</i> | | | | 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (9-12) <i>9 years</i> College (1-4 or 5+) <i>Housewife</i> | | | |
| 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <i>Housewife</i> | | | | 16b. KIND OF BUSINESS/INDUSTRY <i>Own Home</i> | | | |
| 17. FATHER'S NAME (First, Middle, Last) <i>Charles Jones</i> | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) <i>Mollie Betz</i> | | | |
| 19a. INFORMANT'S NAME (Type/Print) <i>Walter Brown</i> | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>431 Pembroke Blvd. Baltimore, Maryland 21224</i> | | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <i>Oak Lawn Cemetery</i> | | | |
| 20c. DATE <i>7/18</i> | | | | 20d. LOCATION — City or Town, State <i>Baltimore, Maryland</i> | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i> | | | | 22. NAME AND ADDRESS OF FACILITY <i>Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Avenue Dundalk, Maryland 21222</i> | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Cerebral vascular accident</i> DUE TO (OR AS A CONSEQUENCE OF): a. <i>Myocardial infarction</i> DUE TO (OR AS A CONSEQUENCE OF): b. <i>Depression</i> DUE TO (OR AS A CONSEQUENCE OF): c. <i>Depression</i> DUE TO (OR AS A CONSEQUENCE OF): d. <i>Depression</i> Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | | | | |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | | | | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY <i>M</i> | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | 28g. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER <i>D. V. Edwards, M.D.</i> | | | | 29c. LICENSE NUMBER <i>D21696</i> | | 29d. DATE SIGNED (Month, Day, Year) <i>7/17/95</i> | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>1576 Merritt Blvd - Balto. MD 21222</i> | | | | | | | |
| 31. DATE FILED (Month, Day, Year) <i>July 18, 1995</i> | | REGISTRAR'S SIGNATURE <i>[Signature]</i> | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 21666

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|---|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) Joseph William Braun | | | | 2. DATE OF DEATH MONTH July DAY 18 , YEAR 1995 | | 3. TIME OF DEATH 7:10 AM | |
| 4. SOCIAL SECURITY NUMBER 043-07-9615 | | 5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 85 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) June 18, 1910 | |
| 8. BIRTHPLACE (State or Foreign Country) New Jersey | | | | 9a. FACILITY NAME (If not institution, give street and number) Meridian at Franklin Woods | | 9b. CITY, TOWN OR LOCATION OF DEATH Essex | |
| 9c. COUNTY OF DEATH Baltimore County | | | | 10a. STATE Maryland | | 10b. COUNTY Balto City | |
| 10c. CITY, TOWN OR LOCATION Baltimore | | | | 10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | 10e. STREET AND NUMBER 1339 W. 41st Street | |
| 10f. ZIP CODE 21211 | | 10g. CITIZEN OF WHAT COUNTRY? USA | | 11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | |
| 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: white | | 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 8+) Business Agent | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired.) Business Agent | |
| 16b. KIND OF BUSINESS/INDUSTRY Ornamental Ironworkers Union | | 17. FATHER'S NAME (First, Middle, Last) Joseph Henry Braun | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Eloise Cook | | 19a. INFORMANT'S NAME (Type/Print) Gladys B. King | |
| 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 144 Kirwans Landing Lane Chester, Maryland 21619 | | 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Gardens of Faith Mem Grdns 7/21 | | 20c. LOCATION — City or Town, State Fullerton, MD | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Jacques H. Carpenter</i> | | 22. NAME AND ADDRESS OF FACILITY Burgee-Henss Funeral Home 3631 Falls Road Baltimore, MD 21211 | | 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Carcinoma of the Liver DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | Approximate Interval Between Onset and Death 6 mos. | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Old Myocardial Infarction | | | | 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | |
| 27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28e. DESCRIBE HOW INJURY OCCURRED | | 29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i> | |
| 29c. LICENSE NUMBER D17728 | | 29d. DATE SIGNED (Month, Day, Year) 7/19/95 | | 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Ba Yin Oung, M.D. 8022 Belair Rd. Balto., Md. 21236 | | 31. DATE FILED (Month, Day, Year) JUL 19 1995 | |
| 32. REGISTRAR'S SIGNATURE <i>[Signature]</i> | | | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

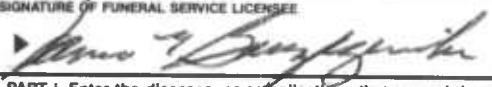

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 21667

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) MARGARET BONTA | | | | 2. DATE OF DEATH MONTH JULY DAY 18 YEAR 1995 | | 3. TIME OF DEATH 7:40 a.m. | |
| 4. SOCIAL SECURITY NUMBER 142-42-4357 | | 5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 87 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) Nov. 5, 1907 | |
| 9a. FACILITY NAME (If not institution, give street and number) GREATER BALTIMORE MEDICAL CENTER | | | | 9b. CITY, TOWN OR LOCATION OF DEATH TOWSON | | 9c. COUNTY OF DEATH BALTIMORE | |
| RESIDENCE OF DECEDENT | | | | | | | |
| 10a. STATE Maryland | | 10b. COUNTY Baltimore | | 10c. CITY, TOWN OR LOCATION Phoenix | | 10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| 10e. STREET AND NUMBER 13723 Manda Mill Lane | | | | 10f. ZIP CODE 21131 | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No - If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE - American Indian, Black, White, etc. Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Housewife | | 16b. KIND OF BUSINESS/INDUSTRY Own Home | | | |
| 17. FATHER'S NAME (First, Middle, Last) Sila C. Ide | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Dora Albertson | | | |
| 19a. INFORMANT'S NAME (Type/Print) William Bonta | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13723 Manda Mill Lane Phoenix, MD. 21131 | | | |
| 20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Greenmount Crematory 7/19/1995 Baltimore | | 20c. LOCATION - City or Town, State | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE  | | | | 22. NAME AND ADDRESS OF FACILITY Brzudzinski Funeral Home P.A. 1407 Old Eastern Ave. Balt., MD. 21221 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → Cardiac arrest | | | | | | | |
| a. DUE TO (OR AS A CONSEQUENCE OF): Sepsis | | | | | | | |
| b. DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| c. DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| d. DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | | | | |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | | | | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 28d. DESCRIBE NOW INJURY OCCURRED | | | | 28e. PLACE OF INJURY - At home, farm, street, factory, office building, etc. (Specify) | | | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER Mark Lamos MD | | | | 29c. LICENSE NUMBER 034521 | | 29d. DATE SIGNED (Month, Day, Year) 7-17-95 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) MARK LAMOS 3346 Papermill RD Phoenix-MD 21131 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JULY 9 1995 | | 32. REGISTRAR'S SIGNATURE  | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 21668

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) <u>Monica M. Boerschel</u> | | | | 2. DATE OF DEATH MONTH <u>July</u> DAY <u>13</u> YEAR <u>1995</u> | | 3. TIME OF DEATH <u>02:45</u> <u>A</u> <u>M</u> | |
| 4. SOCIAL SECURITY NUMBER <u>213-05-1011</u> | | 5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) <u>87</u> YRS. | | 7. DATE OF BIRTH (Month, Day, Year) <u>Dec. 27, 1907</u> | |
| 8. BIRTHPLACE (State or Foreign Country) <u>Maryland</u> | | | | 9a. FACILITY NAME (If not institution, give street and number) <u>St. Agnes Hospital</u> | | 9b. CITY, TOWN OR LOCATION OF DEATH <u>Baltimore</u> | |
| 9c. COUNTY OF DEATH <u>N/A</u> | | | | 10a. STATE <u>Maryland</u> | | 10b. COUNTY <u>N/A</u> | |
| 10c. CITY, TOWN OR LOCATION <u>Baltimore</u> | | | | 10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 10e. STREET AND NUMBER <u>3402 Dudley Avenue</u> | |
| 10f. ZIP CODE <u>21213</u> | | | | 10g. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | | 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: <u>White</u> | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <u>12th grade</u> College (1-4 or 5+) <u></u> | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <u>Telephone Operator</u> | | 16b. KIND OF BUSINESS/INDUSTRY <u>Western Union</u> | |
| 17. FATHER'S NAME (First, Middle, Last) <u>George McLean</u> | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) <u>Margaret Lorick</u> | | | |
| 19a. INFORMANT'S NAME (Type/Print) <u>Paul Boerschel (Son)</u> | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>1649 Woodstock Road, Woodstock, Md. 21163</u> | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <u>Most Holy Redeemer Cem. 7/15/95</u> | | 20c. LOCATION — City or Town, State <u>Baltimore, Maryland</u> | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <u>[Signature]</u> | | | | 22. NAME AND ADDRESS OF FACILITY <u>Schimunek Funeral Home</u> <u>3331 Brehms Lane, Baltimore, Md. 21213</u> | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <u>a. Aspiration pneumonia.</u> DUE TO (OR AS A CONSEQUENCE OF): b. <u></u> DUE TO (OR AS A CONSEQUENCE OF): c. <u></u> DUE TO (OR AS A CONSEQUENCE OF): d. <u></u> Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u></u> | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined | | | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY <u>M</u> | |
| 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER <u>[Signature], M.D., Resident</u> | | | | 29c. LICENSE NUMBER <u>D36942</u> | | 29d. DATE SIGNED (Month, Day, Year) <u>July 13, 1995</u> | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <u>MUNIR RAHAL, 900 CATON AVE, Baltimore, MD, 21229</u> | | | | | | | |
| 31. DATE FILED (Month, Day, Year) <u>JUL 19 1995</u> | | | | 32. REGISTRAR SIGNATURE <u>[Signature]</u> | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 21669

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|---|--|--|---|
| 1. DECEDENT'S NAME (First, Middle, Last) MARTHA S. BOROWSKI | | | | 2. DATE OF DEATH MONTH DAY YEAR 7-16-95 | | 3. TIME OF DEATH 11:15 A M | |
| 4. SOCIAL SECURITY NUMBER 217-09-0469 | | 5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 79 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 11-20-16 | |
| 9a. FACILITY NAME (If not institution, give street and number) 2801 FAIT AVENUE | | | | 9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE | | 9c. COUNTY OF DEATH N/A | |
| 10a. STATE MARYLAND | | | | 10b. COUNTY N/A | | 10c. CITY, TOWN OR LOCATION BALTIMORE | |
| 10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | | | | |
| 10e. STREET AND NUMBER 2801 FAIT AVENUE | | | | 10f. ZIP CODE 21224 | | 10g. CITIZEN OF WHAT COUNTRY? USA | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: WHITE | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 7 YEARS College (1-4 or 5+) _____ | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) CLERK | | 16b. KIND OF BUSINESS/INDUSTRY OWN BUSINESS | | | |
| 17. FATHER'S NAME (First, Middle, Last) HENRY MIERZWINSKI | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) JOSEPHINE KONIECZNA | | | |
| 19a. INFORMANT'S NAME (Type/Print) MRS. MARCIA WOLF | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13716 AMANDA MILL LN. PHOENIX, MD. 21131 | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) HOLY ROSARY CEMETERY | | 20c. LOCATION — City or Town, State 7-19 BALTO. CO. MD. | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Charles R. Borowski</i> | | | | 22. NAME AND ADDRESS OF FACILITY KACZOROWSKI FUNERAL HOME 2525 FLEET ST. BALTO. MD. 21224 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <i>Cardiac - Pul. Arrest</i> DUE TO (OR AS A CONSEQUENCE OF): b. <i>Coronary Artery Disease</i> DUE TO (OR AS A CONSEQUENCE OF): c. _____ DUE TO (OR AS A CONSEQUENCE OF): d. _____ Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | | Approximate Interval Between Onset and Death |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/> | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER <i>M. Wolensky M.D.</i> | | | | 29c. LICENSE NUMBER D-27921 | | 29d. DATE SIGNED (Month, Day, Year) 7/19/95 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 3411 Bancroft St. Balt. 21224 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JUL 19 1995 | | | | 32. REGISTRAR'S SIGNATURE <i>John A. H. H. H.</i> | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR
STATE
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | | | | |
|--|--|---|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) BLAINE MAYNARD CRABILL | | | | 2. DATE OF DEATH MONTH DAY YEAR JULY 18, 1995 | | 3. TIME OF DEATH 7:12 A M | |
| 4. SOCIAL SECURITY NUMBER 219-01-3220 | | 5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 75 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) SEPT. 15, 1919 | |
| 8. BIRTHPLACE (State or Foreign Country) MARYLAND | | | | 9a. CITY, TOWN OR LOCATION OF DEATH BALTIMORE | | 9c. COUNTY OF DEATH N/A | |
| 9b. FACILITY NAME (If not institution, give street and number) 2 S. PROSPECT AVENUE | | | | 10. RESIDENCE OF DECEDENT | | | |
| 10a. STATE MARYLAND | | 10b. COUNTY BALTIMORE | | 10c. CITY, TOWN OR LOCATION N/A | | 10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 10e. STREET AND NUMBER 2. S. PROSPECT AVENUE | | | | 10f. ZIP CODE 21228 | | 10g. CITIZEN OF WHAT COUNTRY? USA | |
| 11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES 1941 - 1945 | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: WHITE | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 12 | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) CLERK | | 16b. KIND OF BUSINESS/INDUSTRY CITY OF BALTIMORE | | | |
| 17. FATHER'S NAME (First, Middle, Last) SILAS CRABILL | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) MAMIE TOMS | | | |
| 19a. INFORMANT'S NAME (Type/Print) LORRAINE M. CRABILL | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 S. PROSPECT AVENUE, BALTIMORE, MD 21228 | | | |
| 20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) FORT LINCOLN CREMATORY 07/19/95 | | 20c. LOCATION — City or Town, State BRENTWOOD, MARYLAND | | 20d. DATE 07/19/95 | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Thel E. Pine</i> | | | | 22. NAME AND ADDRESS OF FACILITY LOUDON PARK FUNERAL HOME 3620 WILKENS AVENUE, BALTIMORE, MD 21229 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | | a. <i>Myocardial Infarction</i> DUE TO (OR AS A CONSEQUENCE OF): | | | | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST | | b. <i>Coronary Artery Disease</i> DUE TO (OR AS A CONSEQUENCE OF): | | | | | |
| | | c. _____ DUE TO (OR AS A CONSEQUENCE OF): | | | | | |
| | | d. _____ DUE TO (OR AS A CONSEQUENCE OF): | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Transverse myelitis</i> <i>Atrial Fibrillation, chronic</i> | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO | | | | | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| | | 28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28e. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER <i>J. William Cook</i> | | | | 29c. LICENSE NUMBER 044243 | | 29d. DATE SIGNED (Month, Day, Year) July 18 1995 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) J. WILLIAM COOK, MD 516 N. ROLLING ROAD SUITE 108 CATONSVILLE, MD 21228 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JUL 19 1995 | | | | 32. REGISTRAR'S SIGNATURE <i>John Davidson-Randall</i> | | | |

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 21671

Item 19b, g-725, 7-19-95, perf. h., dk

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|--|--|---|--|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last) IVANHOE MILTON DEWITT COUSINS JR. | | | | 2. DATE OF DEATH MONTH DAY YEAR July 18 1995 | | 3. TIME OF DEATH 3:30 A M | |
| 4. SOCIAL SECURITY NUMBER 213-76-4694 | | 5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 35 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) APR. 20, 1960 | |
| 9a. FACILITY NAME (If not institution, give street and number) STELLA MARIS HOSPICE | | | | 9b. CITY, TOWN OR LOCATION OF DEATH TOWSON, MARYLAND | | 9c. COUNTY OF DEATH BALTIMORE | |
| 10a. STATE MARYLAND | | | | 10b. COUNTY n/a | | 10c. CITY, TOWN OR LOCATION BALTIMORE | |
| 10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | | | 10e. STREET AND NUMBER 2018 BURNWOOD ROAD, BALTIMORE, MD | | | |
| 10f. ZIP CODE 21239 | | | | 10g. CITIZEN OF WHAT COUNTRY? UNITED STATES | | | |
| 11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: BLACK | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 TH | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) PAINTER | | 16b. KIND OF BUSINESS/INDUSTRY N/A | | | |
| 17. FATHER'S NAME (First, Middle, Last) IVANHOE COUSINS SR. | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) ALEASE WINSTON | | | |
| 19a. INFORMANT'S NAME (Type/Print) ALEASE RODGERS | | | | 19b. MAILING ADDRESS (Rural Route Number, City or Town, State, Zip Code) 2018 BURNWOOD, BALTIMORE, MARYLAND 21239 | | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) DULANEY VALLEY CEMETERY | | 20c. LOCATION — City or Town, State 7-21 TOWSON, MARYLAND | | 20d. DATE | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE D. Valencia Holland | | | | 22. NAME AND ADDRESS OF FACILITY WM. C. MARCH FH.-1101 E. NORTH AVENUE | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Aids DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | Approximate Interval Between Onset and Death 6 yrs. |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO | | | | | | | DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/> |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) HOSPICE | | | | | |
| 27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER Kendall R Faulkner | | | | 29c. LICENSE NUMBER D25643 | | 29d. DATE SIGNED (Month, Day, Year) July 18, 1995 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) DR. KENDALL FAULKNER 2300 DULANEY VALLEY RD. TOWSON, MD 21204 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) Jul 19 1995 | | | | 32. REGISTRAR'S SIGNATURE John W. ... | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the physician attending physician.


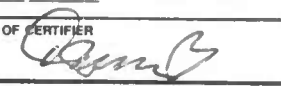
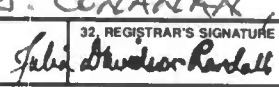
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be delivered to the funeral-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 21672

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|---|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) CARLOTTA E. CROSBY | | | | 2. DATE OF DEATH MONTH July DAY 17 YEAR 1995 | | 3. TIME OF DEATH 6:25 PM | |
| 4. SOCIAL SECURITY NUMBER 225-56-3800 | | 5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 53 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) June 10 1942 | |
| 9a. FACILITY NAME (If not institution, give street and number) North West Hospital Center | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Randallstown | | 9c. COUNTY OF DEATH Baltimore | |
| RESIDENCE OF DECEDENT | | | | | | | |
| 10a. STATE Maryland | | 10b. COUNTY Baltimore | | 10c. CITY, TOWN OR LOCATION Reisterstown | | 10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 10e. STREET AND NUMBER 102 Glyndon Drive | | | | 10f. ZIP CODE 21136 | | 10g. CITIZEN OF WHAT COUNTRY? USA | |
| 11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: white | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 2 College (1-4 or 5+) 2 | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Medical Secretary | | 16b. KIND OF BUSINESS/INDUSTRY Doctors office | | | |
| 17. FATHER'S NAME (First, Middle, Last) Earl STRICKLER | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Rosa L. LAYMAN | | | |
| 19a. INFORMANT'S NAME (Type/Print) Louis C. Crosby | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 102 Glyndon Drive, Reisterstown, MD 21136 | | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Rest Haven Cemetery 7/22 | | 20c. LOCATION — City or Town, State Harrisonburg, VA | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE  | | | | 22. NAME AND ADDRESS OF FACILITY HUBBARD FUNERAL HOME, INC 407 WILKENS AVE BALTO MD 21229 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → ACUTE LIVER FAILURE | | | | | | | |
| Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | | |
| a. DUE TO (OR AS A CONSEQUENCE OF): LIVER CIRRHOSIS | | | | | | | |
| b. DUE TO (OR AS A CONSEQUENCE OF): HEPATITIS B | | | | | | | |
| c. DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| d. DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ENDSTAGE RENAL DISEASE | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) N/A | | 28b. TIME OF INJURY N/A | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED N/A | | | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) N/A | | | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) N/A | | | | | | | |
| 29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER  M.D. | | | | 29c. LICENSE NUMBER D 19502 | | 29d. DATE SIGNED (Month, Day, Year) July 17, 1995 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) ORLANDO B. CONANAN M.D. NORTHWEST HOSPITAL CENTER RANDALLSTOWN MD. 21133 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JUN 19 1995 | | 32. REGISTRAR'S SIGNATURE  | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 21673

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) Helen Elizabeth Chesil | | | | 2. DATE OF DEATH MONTH July DAY 15 YEAR 1995 | | 3. TIME OF DEATH 8:10 A.M. | |
| 4. SOCIAL SECURITY NUMBER 215-40-8888 | | 5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 59 YRS. | | 7. DATE OF BIRTH MONTH May DAY 5 YEAR 1936 | |
| 8. BIRTHPLACE (State or Foreign Country) Maryland | | | | 9a. FACILITY NAME (If not institution, give street and number) 629 McCabe Ave. | | 9b. CITY, TOWN OR LOCATION OF DEATH Baltimore | |
| 9c. COUNTY OF DEATH N/A | | | | 10a. STATE Maryland | | 10b. COUNTY N/A | |
| 10c. CITY, TOWN OR LOCATION Baltimore | | | | 10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | 10e. STREET AND NUMBER 629 McCabe Ave. | |
| 10f. ZIP CODE 21212 | | | | 10g. CITIZEN OF WHAT COUNTRY? USA | | 11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: Black | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 0 | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Nurse's Aide | | 16b. KIND OF BUSINESS/INDUSTRY Nursing Home | | | |
| 17. FATHER'S NAME (First, Middle, Last) Charles Reynolds | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Janie Casterlow | | | |
| 19a. INFORMANT'S NAME (Type/Print) Doreen Chesil | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 629 McCabe Ave. Balto. Md. | | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Pleasant Rest 7/17/95 | | 20c. LOCATION — City or Town, State Towson, Md. | | 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Joseph L. Russ | |
| 22. NAME AND ADDRESS OF FACILITY Joseph L. Russ Funeral Home | | 2222 W. North Ave. Balto. Md. 21216 | | 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. Myocardial Infarction DUE TO (OR AS A CONSEQUENCE OF): b. Atherosclerosis DUE TO (OR AS A CONSEQUENCE OF): c. Diabetes Mellitus DUE TO (OR AS A CONSEQUENCE OF): d. End Stage Renal Disease | | | |
| 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER David H Madoff MD, PhD | | | | 29c. LICENSE NUMBER D31419 | | 29d. DATE SIGNED (Month, Day, Year) 7/17/95 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) David H Madoff MD, PhD 5601 Loch Raven Blvd, Baltimore, Md 21237-2975 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) 7/19/95 | | 32. REGISTRAR'S SIGNATURE John Andrew Karsch | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 21674

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) Harold Charles Colwill | | | | 2. DATE OF DEATH MONTH DAY YEAR July 17, 1995 | | 3. TIME OF DEATH 7:04p | |
| 4. SOCIAL SECURITY NUMBER 214-01-8710 | | 5. SEX 1 <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 78 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) Oct. 4, 1916 | |
| 9a. FACILITY NAME (If not institution, give street and number) 2498 Lewis Lane | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Finksburg | | 9c. COUNTY OF DEATH Carroll Co. | |
| 10a. STATE MD | | | | 10b. COUNTY Carroll | | 10c. CITY, TOWN OR LOCATION Finksburg | |
| 10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | 10e. STREET AND NUMBER 2498 Lewis Lane | | | |
| 10f. ZIP CODE 21048 | | | | 10g. CITIZEN OF WHAT COUNTRY? USA | | | |
| 11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR OATES WWII | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: white | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) College | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Architects Supervisor | | 16b. KIND OF BUSINESS/INDUSTRY Construction | |
| 17. FATHER'S NAME (First, Middle, Last) Edward G. Colwill | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Lydia B. Milton | | | |
| 19a. INFORMANT'S NAME (Type/Print) Linda C. Gosson | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 607 Cockeysville Rd, Reisterstown, MD 21136 | | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Garrison Forest Vet. Cem 7/20/95 | | 20c. LOCATION — City or Town, State Owings Mills, MD | | 20d. DATE 7/20/95 | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | | | | 22. NAME AND ADDRESS OF FACILITY 11824 Reisterstown Rd. Eline Funeral Home Reisterstown, MD 21136 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | | malignant mesothelioma | | | | Approximate Interval Between Onset and Death 15mo | |
| Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | b. DUE TO (OR AS A CONSEQUENCE OF): | | | | | |
| | | c. DUE TO (OR AS A CONSEQUENCE OF): | | | | | |
| | | d. DUE TO (OR AS A CONSEQUENCE OF): | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER | | | | 29c. LICENSE NUMBER D36814 | | 29d. DATE SIGNED (Month, Day, Year) 7/18/95 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Richard L. Huske 7505 Osler Dr, Suite 504 Towson MD 21204 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JUL 19 1995 | | | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.




TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 21675

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) Jennie Chojnowski | | | | 2. DATE OF DEATH MONTH DAY YEAR July 14, 1995 | | 3. TIME OF DEATH 7:14 A. M | |
| 4. SOCIAL SECURITY NUMBER 199-14-8806 | | 5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 71 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) July 20, 1923 | |
| 9a. FACILITY NAME (If not institution, give street and number) 15 S. Washington Street | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Baltimore | | 9c. COUNTY OF DEATH N/A | |
| 10a. STATE Maryland | | | | 10b. COUNTY N/A | | 10c. CITY, TOWN OR LOCATION Baltimore | |
| 10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | | | 10e. STREET AND NUMBER 15 S. Washington Street | | | |
| 10f. ZIP CODE 21231 | | | | 10g. CITIZEN OF WHAT COUNTRY? USA | | | |
| 11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12th | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Billing Clerk | | 16b. KIND OF BUSINESS/INDUSTRY Municipal Government | | | |
| 17. FATHER'S NAME (First, Middle, Last) Gabriel Kuter | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Antoinette Unknown | | | |
| 19a. INFORMANT'S NAME (Type/Print) Mary Ann Hartka | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 156 Downing Drive Severna Park, Maryland 21146 | | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) St. Stanislaus Cemetery | | DATE 7/19 | | 20c. LOCATION — City or Town, State Baltimore, Maryland | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE  | | | | 22. NAME AND ADDRESS OF FACILITY David J. Weber Funeral Home 401 S. Chester St. Baltimore, Md. 21231 | | | |
| 23. PART I. Enter the disease or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Myocardial Infarction DUE TO (OR AS A CONSEQUENCE OF): b. Cerebral Artery Disease DUE TO (OR AS A CONSEQUENCE OF): c. Atherosclerosis DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | | | 28e. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER  | | | | 29c. LICENSE NUMBER 04276 | | 29d. DATE SIGNED (Month, Day, Year) 7.18.95 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 2900 Baltimore Street | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JUL 19 1995 | | | | 32. REGISTRAR'S SIGNATURE  | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 21676

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) Darlene Ann Calligan | | | | 2. DATE OF DEATH MONTH DAY YEAR July 16, 1995 | | 3. TIME OF DEATH 2:35p^m | |
| 4. SOCIAL SECURITY NUMBER 482 36 8136 | | 5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 62 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) Sept. 29, 1932 | |
| 8. BIRTHPLACE (State or Foreign Country) Iowa | | | | 9a. FACILITY NAME (If not institution, give street and number) 1713 Anne Avenue | | 9b. CITY, TOWN OR LOCATION OF DEATH Essex | |
| 9c. COUNTY OF DEATH Baltimore | | | | 10a. STATE Maryland | | 10b. COUNTY Baltimore | |
| 10c. CITY, TOWN OR LOCATION Essex | | | | 10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 10e. STREET AND NUMBER 1713 Anne Avenue | |
| 10f. ZIP CODE 21221 | | | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | | 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) College | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Homemaker | | 16b. KIND OF BUSINESS/INDUSTRY Own Home | |
| 17. FATHER'S NAME (First, Middle, Last) Clarence Diercks | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Ester Tribon | | | |
| 19a. INFORMANT'S NAME (Type/Print) Richard A. Calligan Sr. | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1713 Anne Avenue Baltimore, Maryland 21221 | | | |
| 20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Greenmount Crematory 7/18/95 | | 20c. LOCATION — City or Town, State Baltimore, Maryland | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | | | | 22. NAME AND ADDRESS OF FACILITY Bruzdzinski Funeral Home P.A. 1407 Eastern Ave Baltimore Maryland 21221 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → LIVER FAILURE Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST METASTATIC CARCINOMA OF THE BREAST | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER | | | | 29c. LICENSE NUMBER D29802 | | 29d. DATE SIGNED (Month, Day, Year) 7-17-95 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) SCOTT E. MAIZEL 9000 Franklin Sq Dr Balt 21237 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JUL 19 1995 | | | | 32. REGISTRAR'S SIGNATURE | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 21677

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|--|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) Ellen CRIPPS | | | | 2. DATE OF DEATH MONTH DAY YEAR July 14, 1995 | | 3. TIME OF DEATH 604 pm. | |
| 4. SOCIAL SECURITY NUMBER 218-12-8424 | | 5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 92 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) Dec. 2, 1902 | |
| 8. BIRTHPLACE (State or Foreign Country) West Virginia | | | | 9a. FACILITY NAME (If not institution, give street and number) Franklin Square Hospital | | 9b. CITY, TOWN OR LOCATION OF DEATH Rossville | |
| 9c. COUNTY OF DEATH Baltimore County | | | | 10a. STATE Maryland | | 10b. COUNTY Baltimore | |
| 10c. CITY, TOWN OR LOCATION Essex | | | | 10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 10e. STREET AND NUMBER 1207 "C" Middleborough Road | |
| 10f. ZIP CODE 21221 | | | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | | 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) College | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Book Keeper | | 16b. KIND OF BUSINESS/INDUSTRY Counseling Program | |
| 17. FATHER'S NAME (First, Middle, Last) William F. Fadum | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Evelyn Mullan | | | |
| 19a. INFORMANT'S NAME (Type/Print) Susan Forster | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2128 Rosalie Ave. Essex, Maryland 21221 | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Dulaney Valley Mem. Gardens 7/17/1995 | | 20c. LOCATION — City or Town, State Towson, MD. | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | | | | 22. NAME AND ADDRESS OF FACILITY Brzdzinski Funeral Home P.A. 1407 Old Eastern Ave. Essex, MD 21221 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Cardiopulmonary Arrest DUE TO (OR AS A CONSEQUENCE OF): b. Bronchogenic Carcinoma DUE TO (OR AS A CONSEQUENCE OF): c. Severely Chronic Obstructive Pulmonary Disease and Cor Pulmonale DUE TO (OR AS A CONSEQUENCE OF): d. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/> Approximate Interval Between Onset and Death 40 years | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Severely Chronic Obstructive Pulmonary Disease and Cor Pulmonale | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER | | | | 29c. LICENSE NUMBER RD1992 | | 29d. DATE SIGNED (Month, Day, Year) July 14, 1995 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) J.S. Rana M.D. 9000 Franklin Square Drive, Baltimore, Maryland 21237 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JUL 19 1995 | | | | 32. REGISTRAR'S SIGNATURE | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 21678

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) William H. Clanton | | | | 2. DATE OF DEATH MONTH DAY YEAR July 18 1995 | | 3. TIME OF DEATH 1:15 A M | |
| 4. SOCIAL SECURITY NUMBER 213-09-1721 | | 5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 8. AGE (In yrs. last birthday) 80 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 5-18-15 | |
| 9a. FACILITY NAME (If not institution, give street and number) Ft. Howard VA | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Edgemere | | 9c. COUNTY OF DEATH Baltimore | |
| RESIDENCE OF DECEDENT | | | | | | | |
| 10a. STATE MD | | 10b. COUNTY Baltimore | | 10c. CITY, TOWN OR LOCATION Turners Station | | 10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 10e. STREET AND NUMBER 400 Maple Lane | | | | 10f. ZIP CODE 21222 | | 10g. CITIZEN OF WHAT COUNTRY? USA | |
| 11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES 43--46 | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: Black | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 9 College (1-4 or 5+) 43--46 | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) laborer | | 16b. KIND OF BUSINESS/INDUSTRY Steel | | | |
| 17. FATHER'S NAME (First, Middle, Last) William H. Clanton, Sr. | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Maggie Porter | | | |
| 19a. INFORMANT'S NAME (Type/Print) Easter E. Clanton | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 400 Maple Lane Balto., Md. 21222 | | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Holly Hills 7/21 Balto., Md. | | 20c. LOCATION — City or Town, State | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE James A. Morton | | | | 22. NAME AND ADDRESS OF FACILITY James A. Morton & Sons 1701 Laurens St. Balto., Md. 21217 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Prostate Cancer DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): Approximate Interval Between Onset and Death 6/20/92 | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | | | 28e. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER Prasad Natari MD | | | | 29c. LICENSE NUMBER F 76423 | | 29d. DATE SIGNED (Month, Day, Year) 7-18-95 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Prasad Natari, MD 9600 North Point Road Fort Howard, MD 21052 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JUL 19 1995 | | | | 32. REGISTRAR'S SIGNATURE John A. ... | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 21679

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|---|--|--|---|
| 1. DECEDENT'S NAME (First, Middle, Last) <u>Evelyn May Cavey</u> | | | | 2. DATE OF DEATH MONTH <u>July</u> DAY <u>9</u> YEAR <u>1995</u> | | 3. TIME OF DEATH <u>1:15 P</u> M | |
| 4. SOCIAL SECURITY NUMBER <u>214-22-1069</u> | | 5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) <u>76</u> YRS. | | 7. DATE OF BIRTH (Month, Day, Year) <u>July 11, 1918</u> | |
| 8. FACILITY NAME (If not institution, give street and number) <u>Ivy Hall Geriatric Center</u> | | | | 9b. CITY, TOWN OR LOCATION OF DEATH <u>Baltimore</u> | | 9c. COUNTY OF DEATH <u>Baltimore</u> | |
| 10a. STATE <u>Maryland</u> | | | | 10b. COUNTY <u>Baltimore</u> | | 10c. CITY, TOWN OR LOCATION <u>Baltimore</u> | |
| 10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | | | | |
| 10e. STREET AND NUMBER <u>1232 S. Marlyn Avenue</u> | | | | 10f. ZIP CODE <u>21221</u> | | 10g. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u> | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: <u>White</u> | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <u>10th Grade</u> College (1-4 or 5+) <u></u> | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <u>Salesperson</u> | | 16b. KIND OF BUSINESS/INDUSTRY <u>Retail Sales</u> | | | |
| 17. FATHER'S NAME (First, Middle, Last) <u>Frank L. Wooden</u> | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) <u>Ruth Wright</u> | | | |
| 19a. INFORMANT'S NAME (Type/Print) <u>Carolyn Aherne (daughter)</u> | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>1232 S. Marlyn Avenue, Baltimore, Md. 21221</u> | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <u>Gardens of Faith Cem. 7/12/95</u> | | 20c. LOCATION — City or Town, State <u>Baltimore, Maryland</u> | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | | | | 22. NAME AND ADDRESS OF FACILITY <u>Schimunek Funeral Home</u> <u>3331 Brehms Lane, Baltimore, Md. 21213</u> | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <u>Lymphoma</u> DUE TO (OR AS A CONSEQUENCE OF): a. <u></u> b. <u></u> c. <u></u> d. <u></u> Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST | | | | | | | Approximate Interval Between Onset and Death <u>4 Mos.</u> |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>Alzheimer's Disease</u> <u>Bipolar Disorder</u> DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |
| 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY <u>M</u> | |
| 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER | | | | 29c. LICENSE NUMBER <u>D17728</u> | | 29d. DATE SIGNED (Month, Day, Year) <u>7/10/95</u> | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <u>Ba Yin Oung, M.D. 8022 Belair Rd. Balto., Md. 21236</u> | | | | | | | |
| 31. DATE FILED (Month, Day, Year) <u>JUL 19 1995</u> | | | | 32. REGISTRAR SIGNATURE | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

P.O. BOX 68760

DIVISION OF VITAL RECORDS

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 21680

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) <i>Raimund Andre' Dent</i> | | | | 2. DATE OF DEATH MONTH DAY YEAR <i>July 16 1995</i> | | 3. TIME OF DEATH <i>9:50p M</i> | |
| 4. SOCIAL SECURITY NUMBER <i>214-86-2741</i> | | 5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) <i>30</i> YRS. | | 7. DATE OF BIRTH (Month, Day, Year) <i>JULY 5, 1965</i> | |
| 9a. FACILITY NAME (If not institution, give street and number) <i>UNIVERSITY HOSPITAL</i> | | | | 9b. CITY, TOWN OR LOCATION OF DEATH <i>BALTIMORE CITY</i> | | 9c. COUNTY OF DEATH <i>n/a</i> | |
| RESIDENCE OF DECEDENT | | | | | | | |
| 10a. STATE <i>MARYLAND</i> | | 10b. COUNTY <i>n/a</i> | | 10c. CITY, TOWN OR LOCATION <i>BALTIMORE</i> | | 10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | |
| 10e. STREET AND NUMBER <i>725 GEORGE STREET apt 13c</i> | | | | 10f. ZIP CODE <i>21201</i> | | 10g. CITIZEN OF WHAT COUNTRY? <i>UNITED STATES</i> | |
| 11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: <i>BLACK</i> | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <i>11 th</i> College (1-4 or 5+) <i>—</i> | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <i>MAINTENANCE- GROUNDS KEEPER - APARTMENT COMPLEX</i> | | 16b. KIND OF BUSINESS/INDUSTRY | | | |
| 17. FATHER'S NAME (First, Middle, Last) <i>ARNOLD DENT</i> | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) <i>JANICE LEWIS</i> | | | |
| 19a. INFORMANT'S NAME (Type/Print) <i>JANICE LEWIS</i> | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>725 GEORGE STREET, BALTIMORE, MD 21201</i> | | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <i>VOSHELL MEMORIAL GARDENS 7-22 DUNDALK, MARYLAND</i> | | 20c. LOCATION — City or Town, State | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>S. Valencia Holland</i> | | | | 22. NAME AND ADDRESS OF FACILITY <i>WM. C. MARCH FH -1101 E. NORTH AVENUE</i> | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | | | | | | | |
| a. <i>Sepsis</i> DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| b. <i>Pneumonia</i> DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| c. <i>AIDS</i> DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| d. | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY <i>M</i> | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| | | 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER <i>Rockelle Cunningham</i> | | | | 29c. LICENSE NUMBER <i>7770</i> | | 29d. DATE SIGNED (Month, Day, Year) <i>July 16, 1995</i> | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>Rockelle Cunningham 22 South Greene St. BALTIMORE, MD 21201</i> | | | | | | | |
| 31. DATE FILED (Month, Day, Year) <i>JUL 19 1995</i> | | | | 32. REGISTRAR SIGNATURE <i>John Andrew Ricketts</i> | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

BALTIMORE, MARYLAND 21215-0020

BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

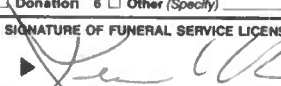
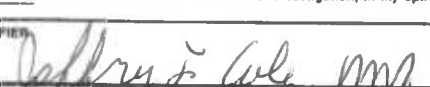
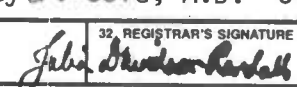
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 21681

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) EDGAR LEON DOVER, SR. | | | | 2. DATE OF DEATH MONTH DAY YEAR July 17, 1995 | | 3. TIME OF DEATH 3:00 A M | |
| 4. SOCIAL SECURITY NUMBER 422-18-5147 | | 5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 70 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) July 26, 1924 | |
| 8. BIRTHPLACE (State or Foreign Country) Alabama | | | | 9a. FACILITY NAME (If not institution, give street and number) 3101 Freeway, 21227 | | 9b. CITY, TOWN OR LOCATION OF DEATH Baltimore (Lansdowne) | |
| 9c. COUNTY OF DEATH Baltimore | | | | 10a. STATE Maryland | | 10b. COUNTY Baltimore | |
| 10c. CITY, TOWN OR LOCATION Baltimore (Lansdowne) | | | | 10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 10e. STREET AND NUMBER 3101 Freeway | |
| 10f. ZIP CODE 21227 | | | | 10g. CITIZEN OF WHAT COUNTRY? USA | | 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES WW 2 Navy | | | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 9 College (1-4 or 5+) 9 | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Retired Outside Machinist | | 16b. KIND OF BUSINESS/INDUSTRY Maryland Drydock and Shipbuilding Co. | |
| 17. FATHER'S NAME (First, Middle, Last) Leon Dover | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Agnes Turner | | | |
| 19a. INFORMANT'S NAME (Type/Print) Mr. Edgar Leon Dover, Jr. | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3101 Freeway, Baltimore, Maryland 21227 | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Meadow Ridge Mem. Pk. July 21, 1995 ElkrIDGE, Maryland | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE  Kevin E. Ecker | | | | 22. NAME AND ADDRESS OF FACILITY McCully Funeral Home of Brooklyn 237 E. Patapsco Ave., Balto., Md. 21225 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <u>Coronary Artery Disease</u> Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>Insulin Dependent Diabetes Mellitus</u> | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | | | | |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | | | | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | |
| 27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | 28d. DESCRIBE HOW INJURY OCCURRED | | | |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER  Jeffrey F. Cole, M.D. | | | | 29c. LICENSE NUMBER D21512 | | 29d. DATE SIGNED (Month, Day, Year) 7/19/95 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Dr. Jeffrey F. Cole, M.D. 3449 Wilkens Ave., Balto., Md. 21229 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JUL 19 1995 | | | | 32. REGISTRAR'S SIGNATURE  | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 21682

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|--|--|--|--|--|--|
| 1. DECEASED'S NAME (First, Middle, Last) Elizabeth Duncan | | | | 2. DATE OF DEATH July 16, 1995 | | 3. TIME OF DEATH 1:12 P M | |
| 4. SOCIAL SECURITY NUMBER 214-68-2463 | | 5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 82 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 10-4-12 | |
| 8a. FACILITY NAME (If not institution, give street and number) Maryland General Hospital | | | | 8b. CITY, TOWN OR LOCATION OF DEATH Baltimore | | 8c. COUNTY OF DEATH n/a | |
| 9a. STATE MD | | 9b. COUNTY n/a | | 9c. CITY, TOWN OR LOCATION Baltimore | | 9d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 10a. STREET AND NUMBER 1027 Cathedral St. | | | | 10b. ZIP CODE 21201 | | 10c. CITIZEN OF WHAT COUNTRY? USA | |
| 11. MARITAL STATUS 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify | | 14. RACE — American Indian, Black, White, etc. Specify: Black | |
| 15. DECEASED'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (9-12) 6th College (1-4 or 5+) | | 16a. DECEASED'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Child Care | | 16b. KIND OF BUSINESS/INDUSTRY Child Care | | | |
| 17. FATHER'S NAME (First, Middle, Last) unk. | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) unk. | | | |
| 19a. INFORMANT'S NAME (Type/Print) Marie M. Jeter | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2507 Round Rd. Balto., MD 21225 | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Mt. Zion Cemetery | | 20c. DATE 7/20 | | 20d. LOCATION — City or Town, State Baltimore, MD | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>James A. Morton</i> | | | | 22. NAME AND ADDRESS OF FACILITY James A. Morton & Sons Funeral Home 1701 Laurens St. Balto., MD 21217 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Respiratory Failure Cardiac Failure b. DUE TO (OR AS A CONSEQUENCE OF): c. Acute Myocardial Infarction d. Acute Renal Failure Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | | Approximate interval Between Onset and Death unknown |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Rule Out Hypertension | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER <i>Tatiana Mouravskaja, M.D.</i> | | | | 29c. LICENSE NUMBER 89224 | | 29d. DATE SIGNED (Month, Day, Year) July 16, 1995 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Tatiana Mouravskaja, M.D. c/o Maryland General Hospital | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JUL 19 1995 | | | | 32. REGISTRAR'S SIGNATURE <i>[Signature]</i> | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR
STATE
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | | | | | | | | |
|--|--|--|--|---|---|---|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) GEORGE FREDERICK DAVIS | | | | 2. DATE OF DEATH MONTH July DAY 15 YEAR 1995 | | 3. TIME OF DEATH 8:30 A | | | | | |
| 4. SOCIAL SECURITY NUMBER 213-07-9347 | | 5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 8. AGE (In yrs. last birthday) 87 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) March 20, 1908 | | 8. BIRTHPLACE (State or Foreign Country) Maryland | | | |
| 9a. FACILITY NAME (If not institution, give street and number) 1324 Roxboro Road | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Rosedale | | | | 9c. COUNTY OF DEATH Baltimore | | | |
| 10a. STATE Maryland | | 10b. COUNTY Baltimore | | 10c. CITY, TOWN OR LOCATION Rosedale | | | | 10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | |
| 10e. STREET AND NUMBER 1324 Roxboro Road | | | | 10f. ZIP CODE 21237 | | 10g. CITIZEN OF WHAT COUNTRY? United States | | | | | |
| 11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | | 14. RACE — American Indian, Black, White, etc. Specify: White | | | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 6th College (1-4 or 5+) College | | 15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Metalurgical Department | | | 15b. KIND OF BUSINESS/INDUSTRY Steel Industry | | | | | | |
| 17. FATHER'S NAME (First, Middle, Last) Unknown | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Unknown | | | | | | | |
| 19a. INFORMANT'S NAME (Type/Print) Patricia M. Koenig | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1324 Roxboro Road Baltimore, Maryland 21237 | | | | | | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Oak Lawn Cemetery 7/18/1995 | | DATE 7/18/1995 | | 20c. LOCATION — City or Town, State Baltimore, Maryland | | | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | | | | 22. NAME AND ADDRESS OF FACILITY Duda-Ruck Funeral Home of Dundalk, Inc 7922 Wise Avenue Baltimore, Maryland 21222 | | | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Congestive Heart Failure DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST Coronary Artery Disease DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | Approximate Interval Between Onset and Death | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Dementia | | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/> | | | | | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | | | |
| 27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED | | | |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | |
| 29. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | | | |
| 30. SIGNATURE AND TITLE OF CERTIFIER | | | | | | 29c. LICENSE NUMBER D36870 | | 29d. DATE SIGNED (Month, Day, Year) 7/17/95 | | | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Peter Vaitkevicius Hopkins Bayview Medical Center | | | | | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JUL 19 1995 | | 32. REGISTRAR'S SIGNATURE | | | | | | | | | |

TO BE COMPLETED BY MEDICAL CERTIFICATION

95 21684

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|---|--|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last) Jay Carroll Dinkelman | | | | 2. DATE OF DEATH MONTH July DAY 15 YEAR 1995 | | 3. TIME OF DEATH 00:02 a m | |
| 4. SOCIAL SECURITY NUMBER 213 70 4120 | | 5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 37 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) Dec. 24, 1957 | |
| 9a. FACILITY NAME (If not institution, give street and number) 8 "C" Alder Drive | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Middle River | | 9c. COUNTY OF DEATH Baltimore | |
| 10a. STATE Maryland | | 10b. COUNTY Baltimore | | 10c. CITY, TOWN OR LOCATION Middle River | | 10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 10e. STREET AND NUMBER 8 "C" Alder Drive | | | | 10f. ZIP CODE 21220 | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 1 College (1-4 or 5+) 1 | | 15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Mechanic | | 16b. KIND OF BUSINESS/INDUSTRY Fork Lift Repair Company | | | |
| 17. FATHER'S NAME (First, Middle, Last) Charles C. Dinkelman | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Dorothy Donley | | | |
| 19a. INFORMANT'S NAME (Type/Print) James R. Dinkelman | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1203 Brandford Road Baltimore, Maryland 21208 | | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Loudon Park Cemetery 7/18/95 | | 20c. LOCATION — City or Town, State Baltimore, Maryland | | | |
| 21. SIGNATURE OF FUNERAL HOME LICENSEE | | | | 22. NAME AND ADDRESS OF FACILITY Bruzdinski Funeral Home P.A. 1407 Eastern Ave Baltimore, Maryland 21221 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → e. Self-inflicted gunshot (handgun) wound to head DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | | Approximate Interval Between Onset and Death |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) 7/15/1995 | | 28b. TIME OF INJURY 00:02 m | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| | | 28d. DESCRIBE HOW INJURY OCCURED self-inflicted | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) Home | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) 8 "C" Alder Drive Balto., Md | |
| 29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER J. Crossan O'Donovan, M.D. | | | | 29c. LICENSE NUMBER D07632 | | 29d. DATE SIGNED (Month, Day, Year) July 17, 1995 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) J. Crossan O'Donovan, M.D. 2112 Dundalk Avenue, Baltimore, Maryland 21222 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JUL 19 1995 | | | | 32. REGISTRAR'S SIGNATURE | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 21685

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|---|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) SOPHIA ELERBEE | | | | 2. DATE OF DEATH MONTH DAY YEAR JULY 15 1995 | | 3. TIME OF DEATH 3:15 A M | |
| 4. SOCIAL SECURITY NUMBER 216-16-8871 | | 5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 88 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 7 25 1906 | |
| 8. BIRTHPLACE (State or Foreign Country) MARYLAND | | | | 9a. FACILITY NAME (If not institution, give street and number) MERIDIAN NURSING HOME | | 9b. CITY, TOWN OR LOCATION OF DEATH CATONSVILLE | |
| 9c. COUNTY OF DEATH BALTIMORE | | | | 10a. STATE MD. | | 10b. COUNTY n/a | |
| 10c. CITY, TOWN OR LOCATION BALTIMORE | | | | 10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 10e. STREET AND NUMBER 16 FRUSTING AVENUE | |
| 10f. ZIP CODE 21228 | | | | 10g. CITIZEN OF WHAT COUNTRY? UNITED STATES | | 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: BLACK | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 6 TH College (1-4 or 5+) — | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) HOUSEKEEPER | | 16b. KIND OF BUSINESS/INDUSTRY outside of home | |
| 17. FATHER'S NAME (First, Middle, Last) JOHN WATERS | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) ELLA HUGHES | | | |
| 19a. INFORMANT'S NAME (Type/Print) BERNICE FRANKLIN | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1411 MADISON AVENUE, BALTIMORE, MD 21217 | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) KING MEMORIAL PARK 7-19 | | 20c. LOCATION — City or Town, State RANDALLSTOWN, MD | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | | | | 22. NAME AND ADDRESS OF FACILITY WM. C. MARCH FH.-1101 E. NORTH AVE. | | | |
| 23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <u>congestive heart failure</u> DUE TO (OR AS A CONSEQUENCE OF): b. <u>Metastatic carcinoma uterus</u> DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>Cerebrovascular accident</u> <u>carcinoma Breast</u> DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/> | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER | | | | 29c. LICENSE NUMBER 225044 | | 29d. DATE SIGNED (Month, Day, Year) 7/18/95 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) M. R. HANNA 2717 Hammonds Ferry Rd 21227 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JUL 19 1995 | | | | 32. REGISTRAR'S SIGNATURE | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760


TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) HERBERT FOUNTAIN | | | | 2. DATE OF DEATH MONTH DAY YEAR 07 16 1995 | | 3. TIME OF DEATH 05:15 A M | |
| 4. SOCIAL SECURITY NUMBER 219-38-8367 | | 5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 8. AGE (In yrs. last birthday) 55 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) Jan. 10 1940 | |
| 9a. FACILITY NAME (If not institution, give street and number) ST. AGNES HOSPITAL | | 9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE | | | | 9c. COUNTY OF DEATH N/A | |
| RESIDENCE OF DECEDENT | | | | | | | |
| 10a. STATE MARYLAND | | 10b. COUNTY N/A | | 10c. CITY, TOWN OR LOCATION BALTIMORE CITY | | 10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 10e. STREET AND NUMBER 1214 KEVIN ROAD | | | | 10f. ZIP CODE 21229 | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: BLACK | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12th grade College (1-4 or 5+) College (1-4 or 5+) | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Retailer | | 16b. KIND OF BUSINESS/INDUSTRY Fish Market | | | |
| 17. FATHER'S NAME (First, Middle, Last) Irving Fountain | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Gertrude Williams | | | |
| 19a. INFORMANT'S NAME (Type/Print) Regina Holmes | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1214 Kevin Road, Baltimore, Maryland 21229 | | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) LOUDON PARK CEMETERY 7/20 | | 20c. LOCATION — City or Town, State BALTIMORE, MARYLAND | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE  | | | | 22. NAME AND ADDRESS OF FACILITY WILLIAM C. BROWN COMMUNITY F/H 1206 W. North Avenue | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | | e. <i>Acute Myocardial Infarction</i> DUE TO (OR AS A CONSEQUENCE OF): | | | | | Approximate Interval Between Onset and Death |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | b. DUE TO (OR AS A CONSEQUENCE OF): | | | | | |
| | | c. DUE TO (OR AS A CONSEQUENCE OF): | | | | | |
| | | d. DUE TO (OR AS A CONSEQUENCE OF): | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO <i>Inspector</i> | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 6 <input type="checkbox"/> Nomicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28e. DESCRIBE HOW INJURY OCCURRED | | | |
| 29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER <i>Theodore M. K...</i> | | | | 29c. LICENSE NUMBER O.C.M.E. | | 29d. DATE SIGNED (Month, Day, Year) 07 16 1995 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) THEODORE M. K... 111 Penn Street, Baltimore, Maryland 21201 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JUL 19 1995 | | | | 32. <i>John H. ...</i> | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 21687

FilmG, 725, item #4, 7/24/95,cyw

1 -
FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) <i>Susie Mary Flores</i> | | | | 2. DATE OF DEATH MONTH <i>07</i> DAY <i>14</i> YEAR <i>95</i> | | 3. TIME OF DEATH <i>725p</i> M | |
| 4. SOCIAL SECURITY NUMBER <i>181-26-1784</i> | | 5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) <i>89</i> YRS. | | 7. DATE OF BIRTH (Month, Day, Year) <i>Sept. 27 1905</i> | |
| 9a. FACILITY NAME (If not institution, give street and number) <i>DETON NURSING HOME</i> | | | | 9b. CITY, TOWN OR LOCATION OF DEATH <i>BALTIMORE CITY</i> | | 9c. COUNTY OF DEATH <i>N/A</i> | |
| 10a. STATE <i>MARYLAND</i> | | | | 10b. COUNTY <i>N/A</i> | | 10c. CITY, TOWN OR LOCATION <i>BALTIMORE CITY</i> | |
| 10e. STREET AND NUMBER <i>5506 WHITBY ROAD</i> | | | | 10f. ZIP CODE <i>21206</i> | | 10g. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i> | |
| 11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: <i>BLACK</i> | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <i>8th grade</i> College (1-4 or 5+) <i>DOMESTIC</i> | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <i>DOMESTIC</i> | | 16b. KIND OF BUSINESS/INDUSTRY <i>UNKNOWN</i> | | | |
| 17. FATHER'S NAME (First, Middle, Last) <i>UNKNOWN</i> | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) <i>IRENE TOWNLEY</i> | | | |
| 19a. INFORMANT'S NAME (Type/Print) <i>ANNA-BYRD IRENE JONES</i> | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>5506 WHITBY ROAD, BALTIMORE, MARYLAND 21206</i> | | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <i>ARBUTUS MEMORIAL PARK</i> | | DATE <i>7/21</i> | | 20c. LOCATION — City or Town, State <i>BALTIMORE, MARYLAND</i> | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Barker A. B.</i> | | | | 22. NAME AND ADDRESS OF FACILITY <i>WILLIAM C. BROWN COMMUNITY F/H 1206 W. NORTH AVENUE</i> | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | | a. <i>Artherosclerotic cardiovascular disease, more than 10 years</i> | | | | | |
| | | b. <i>Coronary artery disease.</i> | | | | | |
| | | c. <i>Hypertension</i> | | | | | |
| | | d. <i>Peripheral vascular disease</i> | | | | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Chronic renal insufficiency. Old Stroke, Decubitus ulcers.</i> | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY <i>M</i> | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| | | 28d. DESCRIBE HOW INJURY OCCURRED | | | | 28e. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature] MD</i> | | 29c. LICENSE NUMBER <i>D44973</i> | | 29d. DATE SIGNED (Month, Day, Year) <i>7/15/95</i> | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>9101 Cherry LANE</i> | | | | | | | |
| 31. DATE FILED (Month, Day, Year) <i>JUL 19 1995</i> | | 32. REGISTRAR'S SIGNATURE <i>John A. Hudson-Randall</i> | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR
STATE
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

BALTIMORE, MARYLAND 21215-0020

BOX 68760

DIVISION OF VITAL RECORDS, P.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

| | | | | | | | | |
|--|--|--|--|--|--|--|--|---|
| 1. DECEDENT'S NAME (First, Middle, Last) HUBERT LONNIE FLEMMING | | | | 2. DATE OF DEATH MONTH DAY YEAR July 12 1995 | | 3. TIME OF DEATH 12:40p M | | |
| 4. SOCIAL SECURITY NUMBER 722-05-0639 | | 5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 72 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) June 30 1923 | | |
| 8. BIRTHPLACE (State or Foreign Country) Georgia | | | | | | | | |
| 9a. FACILITY NAME (If not institution, give street and number) 619 N. Fremont Avenue | | | | 9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE CITY | | 9c. COUNTY OF DEATH N/A | | |
| RESIDENCE OF DECEDENT | | | | | | | | |
| 10a. STATE MARYLAND | | 10b. COUNTY n/a | | 10c. CITY, TOWN OR LOCATION BALTIMORE CITY | | 10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | |
| 10e. STREET AND NUMBER 619 N. FREMONT AVENUE | | | | 10f. ZIP CODE 21217 | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | | |
| 11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES UNKNOWN | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— if yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: BLACK | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 10th grade | | 15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Painter | | 15b. KIND OF BUSINESS/INDUSTRY UNKNOWN | | | | |
| 17. FATHER'S NAME (First, Middle, Last) OTIS FLEMING | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) CARRIE FLEMING | | | | |
| 19a. INFORMANT'S NAME (Type/Print) LFOA Y. WIGGINS | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 619 N. FREMONT AVENUE, BALTIMORE, MARYLAND 21217 | | | | |
| 20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) METRO CREMATORY | | DATE 7/18 | | 20c. LOCATION — City or Town, State BALTIMORE, MARYLAND | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | | | | 22. NAME AND ADDRESS OF FACILITY WILLIAM C. BROWN COMMUNITY F/H 1206 W. NORTH AVENUE | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | Approximate Interval Between Onset and Death | |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Myocardial Infarction DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST { b. _____ DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | |
| c. _____ DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | |
| 29. CERTIFIER <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER | | | | 29c. LICENSE NUMBER D15634 | | 29d. DATE SIGNED (Month, Day, Year) 7-15-95 | | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) S. KULATHAN NGAM, MD, 2020 Belair Road Balto 2123 | | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JUL 19 1995 | | 35. DEPARTMENT OF HEALTH & HUMAN SERVICES | | | | | | |

95 21689

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) JOSEPH T. FISH PAW | | | | 2. DATE OF DEATH MONTH July DAY 14 YEAR 1995 | | 3. TIME OF DEATH 8:10 A M | |
| 4. SOCIAL SECURITY NUMBER 218-10-0304 | | 5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 75 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 07-31-19 | |
| 9a. FACILITY NAME (If not institution, give street and number) JOHNS HOPKINS BAY VIEW | | | | 9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE | | 9c. COUNTY OF DEATH N/A | |
| RESIDENCE OF DECEDENT | | | | | | | |
| 10a. STATE PENNSYLVANIA | | 10b. COUNTY OXFORD | | 10c. CITY, TOWN OR LOCATION NEW OXFORD | | 10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 10e. STREET AND NUMBER 419 A. PEACE CIRCLE | | | | 10f. ZIP CODE 17350 | | 10g. CITIZEN OF WHAT COUNTRY? USA | |
| 11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES RET. ARMY | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: WHITE | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 4 YRS. | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) RET. MILITARY ARMY | | 16b. KIND OF BUSINESS/INDUSTRY US. ARMY | | | |
| 17. FATHER'S NAME (First, Middle, Last) JOHN THOMAS FISHPAW | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) MARY. E. SMALL | | | |
| 19a. INFORMANT'S NAME (Type/Print) MRS. GLADYS J. FISHPAW | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 419 A. PEACE CIRCLE NEW OXFORD, PA. 17350 | | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) ARLINGTON NATIONAL CEM. 7-21 | | DATE 7-21 | | 20c. LOCATION — City or Town, State ARLINGTON VA. | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Charles R. Kaczorowski</i> | | | | 22. NAME AND ADDRESS OF FACILITY KACZOROWSKI FUNERAL HOME 2525 FLEET ST. BALTO. MD. 21224 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. METASTATIC CANCER TO BRAIN DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): Approximate interval Between Onset and Death 4 months | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28d. DESCRIBE HOW INJURY OCCURRED | | | |
| 28e. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER <i>Way MD</i> | | | | 29c. LICENSE NUMBER 94016 | | 29d. DATE SIGNED (Month, Day, Year) July 14, 95 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) TIN WAY MD BAYVIEW MEDICAL CTR, BALTIMORE MD. | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JUL 19 1995 | | | | 32. REGISTRAR'S SIGNATURE <i>John A. ...</i> | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

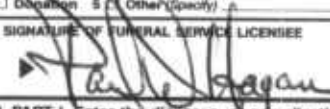
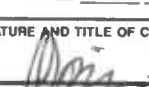

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 21690

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|---|--|---|--|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last) Hilda H. Garey | | | | 2. DATE OF DEATH MONTH DAY YEAR July 14, 1995 | | 3. TIME OF DEATH 7:50 A M | |
| 4. SOCIAL SECURITY NUMBER 218-07-7218 | | 5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 74 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) March 31, 1921 | |
| 9a. FACILITY NAME (If not institution, give street and number) Greater Baltimore Medical Center | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Towson | | 9c. COUNTY OF DEATH Baltimore | |
| RESIDENCE OF DECEDENT | | | | | | | |
| 10a. STATE Maryland | | 10b. COUNTY Baltimore | | 10c. CITY, TOWN OR LOCATION Arbutus | | 10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| 10e. STREET AND NUMBER 1001 Downton Road | | | | 10f. ZIP CODE 21227 | | 10g. CITIZEN OF WHAT COUNTRY? United States | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 10 College (1-4 or 5+) | | 15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Pharmacist | | 15b. KIND OF BUSINESS/INDUSTRY Medical | | | |
| 17. FATHER'S NAME (First, Middle, Last) Julius Zinnert | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Freida Borchett | | | |
| 19a. INFORMANT'S NAME (Type/Print) Arthur Garey | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1001 Downton Road Arbutus, Maryland 21227 | | | |
| 20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Metro Crematory | | DATE 7/15 | | 20c. LOCATION — City or Town, State Catonsville, Maryland | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE  | | | | 22. NAME AND ADDRESS OF FACILITY Ambrose Funeral Home Arbutus 1328 Sulphur spring Road 21227 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Multiple myeloma DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. | | | | | | | Approximate interval between Onset and Death 3 years |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/> | | | | | | | 34a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |
| 34b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 3 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28d. DESCRIBE HOW INJURY OCCURRED | | | | | |
| 28e. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER  | | | | 29c. LICENSE NUMBER PO 8420 | | 29d. DATE SIGNED (Month, Day, Year) July 15, 1995 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Chow, Moping 6701 N. Charles Street 21204 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JUL 19 1995 | | REGISTRAR'S SIGNATURE  | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68750

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 21691

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) John Paton Gabbin | | | | 2. DATE OF DEATH MONTH July DAY 16 YEAR 1995 | | 3. TIME OF DEATH 7:50 A | |
| 4. SOCIAL SECURITY NUMBER 226-12-4007 | | 5. SEX 1 <input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 8. AGE (In yrs. last birthday) 73 YRS. | | 7. DATE OF BIRTH MONTH April DAY 15 YEAR 1922 | |
| 9a. FACILITY NAME (If not institution, give street and number) 3301 Burleith Ave. | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Baltimore | | 9c. COUNTY OF DEATH N/A | |
| 10a. STATE Maryland | | 10b. COUNTY N/A | | 10c. CITY, TOWN OR LOCATION Baltimore | | 10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | |
| 10e. STREET AND NUMBER 3301 Burleith Ave. | | | | 10f. ZIP CODE 21215 | | 10g. CITIZEN OF WHAT COUNTRY? USA | |
| 11. MARITAL STATUS 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: Black | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 1 | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Steel Forger | | 16b. KIND OF BUSINESS/INDUSTRY Steel Company | | | |
| 17. FATHER'S NAME (First, Middle, Last) Lee Gabbin | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Lillie Thompson | | | |
| 19a. INFORMANT'S NAME (Type/Print) Mary Gabbin | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3301 Burleith Ave. Balto. Md. 21215 | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Loundon Park 7/20/95 | | 20c. LOCATION — City or Town, State Balto. Md. | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Joseph L. Russ | | | | 22. NAME AND ADDRESS OF FACILITY Joseph L. Russ Funeral Home 3222 W. North Ave. Balto. Md. 21216 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Sepere Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. DUE TO (OR AS A CONSEQUENCE OF): Carcinoma b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 6 <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER John Paton Gabbin | | | | 29c. LICENSE NUMBER D25902 | | 29d. DATE SIGNED (Month, Day, Year) 7/19/95 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 4713 Leeds Ave Baltimore, MD. 21227/EFEM E. Imoke, md. | | | | | | | |
| 31. DATE FILED (Month, Day, Year) 7/19/95 | | 32. REGISTRAR'S SIGNATURE John Paton Gabbin | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 21692

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|--|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) ROBERT DANIEL GRUEL | | | | 2. DATE OF DEATH MONTH JULY DAY 15 YEAR 1995 | | 3. TIME OF DEATH 11:45 P.M. | |
| 4. SOCIAL SECURITY NUMBER 190 12 9498 | | 5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 70 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) MARCH 3 1925 | |
| 8. BIRTHPLACE (State or Foreign Country) PENNSYLVANIA | | | | 9a. FACILITY NAME (If not institution, give street and number) 2604 Linwood Road | | 9b. CITY, TOWN OR LOCATION OF DEATH PARKVILLE | |
| 9c. COUNTY OF DEATH BALTIMORE | | | | 10a. STATE MARYLAND | | 10b. COUNTY BALTIMORE | |
| 10c. CITY, TOWN OR LOCATION PARKVILLE | | | | 10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 10e. STREET AND NUMBER 2604 Linwood Road | |
| 10f. ZIP CODE 21234 | | | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | | 11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES W.W.II | | | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | | |
| 14. RACE — American Indian, Black, White, etc. Specify: WHITE | | | | 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 YRS. College (1-4 or 5+) TILE SETTER | | | |
| 16. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) TILE SETTER | | | | 16b. KIND OF BUSINESS/INDUSTRY BAUER TILE CO. | | | |
| 17. FATHER'S NAME (First, Middle, Last) HARRY GRUEL | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) MRS. DABRY | | | |
| 19a. INFORMANT'S NAME (Type/Print) CATHERINE M. GRUEL | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2604 Linwood Road PARKVILLE, MARYLAND 21234 | | | |
| 20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) GREEN MOUNT CREMATORY 7-17-95 | | | |
| 20c. LOCATION — City or Town, State BALTIMORE, MARYLAND | | | | 21. SIGNATURE OF FUNERAL SERVICE LICENSEE [Signature] | | | |
| 22. NAME AND ADDRESS OF FACILITY EVANS CHAPEL OF MEMORIES 8800 HARFORD ROAD — PARKVILLE | | | | 23. PART I. Enter the diseases, or complications, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Lung Cancer — metastatic Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO | | | | DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | |
| 27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide | | | | 28a. DATE OF INJURY (Month, Day, Year) 7-17-95 | | | |
| 28b. TIME OF INJURY M | | | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO | | | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | | | 28e. PLACE OF INJURY — At home, farm, street, tectory, office building, etc. (Specify) | | | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | 29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER [Signature] | | | | 29c. LICENSE NUMBER 043172 | | | |
| 29d. DATE SIGNED (Month, Day, Year) JULY 17, 1995 | | | | 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) DR. LISA K. SATTERFIELD 9512 HARFORD ROAD CARNEY, MARYLAND 21234 | | | |
| 31. DATE FILED (Month, Day, Year) JULY 19 1995 | | | | | | | |

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

95 21693

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|---|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) MARY C. GDULA | | | | 2. DATE OF DEATH MONTH DAY YEAR JULY 16, 1995 | | 3. TIME OF DEATH 9:20 A.M. | |
| 4. SOCIAL SECURITY NUMBER 213123089 | | 5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 74 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) NOV 5, 1920 | |
| 8. BIRTHPLACE (State or Foreign Country) MARYLAND | | | | 9. FACILITY NAME (If not institution, give street and number) 1265 NEIGHBORS AVENUE | | | |
| 10. CITY, TOWN OR LOCATION OF DEATH ROSEDALE | | | | 11. COUNTY OF DEATH BALTIMORE | | | |
| 12. STATE MD | | 13. COUNTY BALTIMORE | | 14. CITY, TOWN OR LOCATION ROSEDALE | | 15. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| 16. STREET AND NUMBER 1265 NEIGHBORS AVENUE | | | | 17. ZIP CODE 21237 | | 18. CITIZEN OF WHAT COUNTRY? USA | |
| 19. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 20. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 21. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 22. RACE — American Indian, Black, White, etc. Specify: WHITE | |
| 23. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (14 or 5+) 0 | | 24. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) HOMEMAKER | | 25. KIND OF BUSINESS/INDUSTRY OWN HOME | | | |
| 26. FATHER'S NAME (First, Middle, Last) JACOB WOIZESKO | | | | 27. MOTHER'S NAME (First, Middle, Maiden Surname) ANNA UNK. | | | |
| 28. INFORMANT'S NAME (Type/Print) Lowell M. Gdula | | | | 29. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 44790 Eddy Hill Dr.; Soldatna, Alaska 99669 | | | |
| 30. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 31. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) DULANEY VALLEY 7-20-95 | | 32. LOCATION — City or Town, State TIMONTUM, MARYLAND | | | |
| 33. SIGNATURE OF FUNERAL SERVICE LICENSEE Denis S. Kelly | | | | 34. NAME AND ADDRESS OF FACILITY Cvach/Rosedale Funeral Home 1211 Chesaco Ave. | | | |
| 35. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Coronary artery Disease Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. Hypertensive Cardiovascular Disease c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| 36. PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | |
| 37. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/> | | | | 38. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 39. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 40. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 41. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 42. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 43. DATE OF INJURY (Month, Day, Year) | | 44. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 45. DESCRIBE HOW INJURY OCCURRED | |
| 46. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 47. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | |
| 48. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 49. SIGNATURE AND TITLE OF CERTIFIER Re Mager MD | | | | 50. LICENSE NUMBER D09350 | | 51. DATE SIGNED (Month, Day, Year) 7/17/95 | |
| 52. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) R.S. MAGALI MD 7811 WID AVE BALTO MD 2122 | | | | | | | |
| 53. DATE FILED (Month, Day, Year) JUL 19 1995 | | | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 21694

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|---|--|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last) HELENE D. GARRETT | | | | 2. DATE OF DEATH MONTH 7 DAY 15 YEAR 95 | | 3. TIME OF DEATH 11:03 A M | |
| 4. SOCIAL SECURITY NUMBER 213-07-1688 | | 5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 81 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 12-25-13 | |
| 9a. FACILITY NAME (If not institution, give street and number) 65 WILLOW SPRING ROAD | | | | 9b. CITY, TOWN OR LOCATION OF DEATH DUNDALK | | 9c. COUNTY OF DEATH BALTIMORE | |
| RESIDENCE OF DECEDENT | | | | | | | |
| 10a. STATE MARYLAND | | 10b. COUNTY BALTIMORE | | 10c. CITY, TOWN OR LOCATION DUNDALK | | 10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| 10e. STREET AND NUMBER 65 WILLOW SPRING ROAD | | | | 10f. ZIP CODE 21222 | | 10g. CITIZEN OF WHAT COUNTRY? USA | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: WHITE | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (9-12) 6 YEARS College (1-4 or 5+) _____ | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) WAITRESS | | 16b. KIND OF BUSINESS/INDUSTRY HAUSSNER's rest. | | | |
| 17. FATHER'S NAME (First, Middle, Last) THOMAS KUSYK | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) ANNA ? 4th known | | | |
| 19a. INFORMANT'S NAME (Type/Print) MR. CLARENCE GARRETT | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 65 WILLOW SPRING ROAD BALTO. MD. 21222 | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) GREEN MOUNT CEM | | DATE 7-19 | | 20c. LOCATION — City or Town, State BALTO. MD. | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Charles R. Kaczorowski</i> | | | | 22. NAME AND ADDRESS OF FACILITY KACZOROWSKI FUNERAL HOME 1201 DUNDALK AVE. BALTO. MD. 21222 | | | |
| 23. PART I. Enter the diseases, or complications, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Arrhythmia related to coronary artery disease DUE TO (OR AS A CONSEQUENCE OF): b. Cardiomyopathy DUE TO (OR AS A CONSEQUENCE OF): c. Hypertension DUE TO (OR AS A CONSEQUENCE OF): d. _____ Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | | Approximate Interval Between Onset and Death |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Stroke (cardiac disease), hypertension | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | | | | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/> | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DDA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | 28g. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER <i>Michael Fitzgerald</i> | | | | 29c. LICENSE NUMBER D35761 | | 29d. DATE SIGNED (Month, Day, Year) 7/18/95 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Michael Fitzgerald Johns Hopkins Bayview Medical Center, Baltimore MD 21224 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JUL 19 1995 | | | | 32. REGISTRAR'S SIGNATURE <i>Johanna H. Carroll</i> | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 21695

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|---|---|---|--------------------------------|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) GERALD T. HORSEMAN | | | | 2. DATE OF DEATH MONTH 07 DAY 17 YEAR 1995 | | 3. TIME OF DEATH 12:53 P.M. | |
| 4. SOCIAL SECURITY NUMBER 219.30.0625 | | 5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F | 6. AGE (In yrs. last birthday) 61 YRS. | IF UNDER 1 YEAR MONTHS DAYS | IF UNDER 24 HRS. HOURS MIN. | 7. DATE OF BIRTH (Month, Day, Year) MAY 25, 1934 | |
| 9a. FACILITY NAME (If not institution, give street and number) Atlantic General Hospital | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Berlin | | 9c. COUNTY OF DEATH Worcester | |
| RESIDENCE OF DECEDENT | | | | | | | |
| 10a. STATE MARYLAND | | 10b. COUNTY ANNE ARUNDEL | | 10c. CITY, TOWN OR LOCATION GLEN BURNIE | | 10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | |
| 10e. STREET AND NUMBER 400 DELAWARE AVENUE | | | | 10f. ZIP CODE 21060 | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES 1960 | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: WHITE | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) II | | 15b. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) TRUCK DRIVER | | 16b. KIND OF BUSINESS/INDUSTRY TRANSPORTATION | | | |
| 17. FATHER'S NAME (First, Middle, Last) JAMES HORSEMAN | | | | 16. MOTHER'S NAME (First, Middle, Maiden Surname) MARY LUSCZKAUSHAS | | | |
| 19a. INFORMANT'S NAME (Type/Print) MARGARET HORSEMAN | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 400 DELAWARE AVE. G.B. MD. 21060 | | | |
| 20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) LOUDON PARK CEMETERY | | DATE 7/21 | | 20c. LOCATION — City or Town, State BALTIMORE, MD. | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | | | | 22. NAME AND ADDRESS OF FACILITY HUBBARD FUNERAL HOME, INC. 4107 Wilkens Ave, Baltimore, MD 21229 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | | a. <u>CARDIO PULMONARY ARREST</u> | | | | | |
| | | b. <u>HYPERTENSION</u> | | | | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events that initiated events resulting in death) LAST | | c. DUE TO (OR AS A CONSEQUENCE OF): | | | | | |
| | | d. DUE TO (OR AS A CONSEQUENCE OF): | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>Prostate Cancer, Cirrhosis of Liver</u> <u>Abdominal Aortic Aneurysm, Stroke</u> DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| | | 28d. DESCRIBE NOW INJURY OCCURRED | | | | 28e. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER Raza Hassan M.D. | | | | 29c. LICENSE NUMBER J46227 | | 29d. DATE SIGNED (Month, Day, Year) 7/18/95 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Dr. Raza Hassan 4660 Wilkens Ave, Suite 100 Baltimore, MD 21229 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JUL 19 1995 | | | | 32. REGISTRAR'S SIGNATURE | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 21696

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|---|--|---|--|--|---|
| 1. DECEDENT'S NAME (First, Middle, Last) RICHARD THOMAS HUMPHREYS, SR | | | | 2. DATE OF DEATH MONTH JULY DAY 12 YEAR 1995 | | 3. TIME OF DEATH 5:46 P.M. | |
| 4. SOCIAL SECURITY NUMBER 213 16 3915 | | 5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (in yrs. last birthday) 73 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) MAY 22 1922 | |
| 8. BIRTHPLACE (State or Foreign Country) MARYLAND | | | | 9a. FACILITY NAME (If not Institution, give street and number) ST. JOSEPH HOSPITAL | | 9b. CITY, TOWN OR LOCATION OF DEATH Towson | |
| 9c. COUNTY OF DEATH BALTIMORE | | | | 10a. STATE MARYLAND | | 10b. COUNTY BALTIMORE | |
| 10c. CITY, TOWN OR LOCATION PARKVILLE | | | | 10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 10e. STREET AND NUMBER 2909 HISS AVE | |
| 10f. ZIP CODE 21234 | | | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | | 11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES W-W-II | | | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | | |
| 14. RACE — American Indian, Black, White, etc. Specify: WHITE | | | | 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 YRS. College (1-4 or 5+) POLICE | | | |
| 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) POLICE | | | | 16b. KIND OF BUSINESS/INDUSTRY BETHLEHEM STEEL CORP. | | | |
| 17. FATHER'S NAME (First, Middle, Last) CHARLES THOMAS HUMPHREYS | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) HELEN MARIE NOYES | | | |
| 19a. INFORMANT'S NAME (Type/Print) EMMA LEE M. HUMPHREYS | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2909 HISS AVE PARKVILLE, MARYLAND 21234 | | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) PARKWOOD CEMETERY 7-85 PARKVILLE, MARYLAND | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i> | | | | 22. NAME AND ADDRESS OF FACILITY EVANS CHAPEL OF MEMORIES 8800 HARFORD ROAD - PARKVILLE | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Arteriosclerotic coronary disease artery DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | Approximate Interval Between Onset and Death |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Chronic obstructive pulmonary disease | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO | | | | | | | 25. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/> |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | 29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER Monica C. Kowalski | | | | 29c. LICENSE NUMBER A21022 | | 29d. DATE SIGNED (Month, Day, Year) JULY 13, 1995 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) DR. MARION C. KOWALSKI 8604 HARFORD ROAD - PARKVILLE | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JUL 19 1995 | | | | 32. REGISTRAR'S SIGNATURE <i>[Signature]</i> | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 21697

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|--|--|--|--|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last) <u>Leon Hawkins</u> | | | | 2. DATE OF DEATH MONTH <u>July</u> DAY <u>12</u> YEAR <u>1995</u> | | 3. TIME OF DEATH <u>945 PM</u> M | |
| 4. SOCIAL SECURITY NUMBER <u>218-03-0241</u> | | 5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) <u>76</u> YRS. | | 7. DATE OF BIRTH (Month, Day, Year) <u>May 3, 1919</u> | |
| 9a. FACILITY NAME (If not institution, give street and number) <u>Sinai Hospital</u> | | | | 9b. CITY, TOWN OR LOCATION OF DEATH <u>Baltimore</u> | | 9c. COUNTY OF DEATH <u>N/A</u> | |
| RESIDENCE OF DECEDENT | | | | 10c. CITY, TOWN OR LOCATION <u>Baltimore</u> | | 10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 10a. STATE <u>Maryland</u> | | 10b. COUNTY <u>N/A</u> | | 10e. STREET AND NUMBER <u>4206 Wentworth Rd.</u> | | 10f. ZIP CODE <u>21207</u> | |
| 10g. CITIZEN OF WHAT COUNTRY? <u>USA</u> | | 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <u>12</u> College (1-4 or 5+) <u>0</u> | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <u>Self-employed Entrepreneur</u> | | 16b. KIND OF BUSINESS/INDUSTRY | |
| 17. FATHER'S NAME (First, Middle, Last) <u>Herbert Sterling</u> | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) <u>Eletine Hawkins</u> | | | |
| 19a. INFORMANT'S NAME (Type/Print) <u>Shirley Hawkins</u> | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>4206 Wentworth Rd. Balto. Md. 21207</u> | | | |
| 20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <u>Greenmount</u> | | 20c. LOCATION — City or Town, State <u>Balto. Md.</u> | | 20d. DATE <u>7/17/95</u> | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <u>Joseph L. Russ</u> | | | | 22. NAME AND ADDRESS OF FACILITY <u>Joseph L. Russ Funeral Home</u> <u>2222 W. North Ave. Balto. Md. 21216</u> | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <u>Sepsis</u> DUE TO (OR AS A CONSEQUENCE OF): b. <u>Toxic Metabolic Encephalopathy</u> DUE TO (OR AS A CONSEQUENCE OF): c. <u>Previous Subcortical Stroke/Multi-Infarct Dementia</u> DUE TO (OR AS A CONSEQUENCE OF): d. <u>Endstage Renal Disease - Hemodialysis</u> | | | | | | | Approximate interval Between Onset and Death |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>Hypertension, Secondary Hyperparathyroidism with Recurrent Hypercalcemia</u> | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | | | | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | 28g. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER <u>Diane Tralacoste DO</u> | | | | 29c. LICENSE NUMBER <u>AS240234</u> | | 29d. DATE SIGNED (Month, Day, Year) <u>July 12, 1995</u> | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <u>Diane Tralacoste DO Sinai Hospital of Baltimore MD</u> | | | | | | | |
| 31. DATE FILED (Month, Day, Year) <u>JUL 19 1995</u> | | | | 32. REGISTRAR'S SIGNATURE <u>John Andrew Randall</u> | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 21698

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) <i>Stephanie B. Hock</i> | | | | 2. DATE OF DEATH MONTH <i>July</i> DAY <i>15</i> YEAR <i>1995</i> | | 3. TIME OF DEATH <i>11:12 A.M.</i> | |
| 4. SOCIAL SECURITY NUMBER <i>217-09-5061</i> | | 5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) <i>98</i> YRS. | | 7. DATE OF BIRTH (Month, Day, Year) <i>Nov. 18, 1896</i> | |
| 8. BIRTHPLACE (State or Foreign Country) <i>Poland</i> | | | | 9a. FACILITY NAME (If not institution, give street and number) <i>Fallston General Hospital</i> | | 9b. CITY, TOWN OR LOCATION OF DEATH <i>Fallston</i> | |
| 9c. COUNTY OF DEATH <i>Harford</i> | | | | 10a. STATE <i>Maryland</i> | | 10b. COUNTY <i>N/A</i> | |
| 10c. CITY, TOWN OR LOCATION <i>Baltimore</i> | | | | 10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | 10e. STREET AND NUMBER <i>4784 Elison Avenue</i> | |
| 10f. ZIP CODE <i>21206</i> | | | | 10g. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i> | | 11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced | |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | | |
| 14. RACE — American Indian, Black, White, etc. Specify: <i>White</i> | | | | 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <i>6th grade</i> College (1-4 or 5+) <i>Coat Maker</i> | | | |
| 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <i>Coat Maker</i> | | | | 16b. KIND OF BUSINESS/INDUSTRY <i>Int. Ladies Garment Union</i> | | | |
| 17. FATHER'S NAME (First, Middle, Last) <i>Sylvester Potocki</i> | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) <i>Josephine Sipulski</i> | | | |
| 19a. INFORMANT'S NAME (Type/Print) <i>Marie Zientak (Daughter)</i> | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>1707 Ruger Drive, Bel Air, Md. 21015</i> | | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <i>Holy Rosary Cemetery 7/19/95</i> | | | |
| 20c. LOCATION — City or Town, State <i>Baltimore, Maryland</i> | | | | 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i> | | | |
| 22. NAME AND ADDRESS OF FACILITY <i>Schmunek Funeral Home 3331 Brehms Lane, Baltimore, MD. 21213</i> | | | | 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Cerebrovascular Accident</i> a. DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Arrhythmia Fibrillation</i> | | | | 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/> | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | |
| 27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide | | | | 28a. DATE OF INJURY (Month, Day, Year) <i>7/15/95</i> | | | |
| 28b. TIME OF INJURY <i>M</i> | | | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | |
| 28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28e. DESCRIBE HOW INJURY OCCURRED | | | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | 29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i> | | | |
| 29c. LICENSE NUMBER <i>D 34095</i> | | | | 29d. DATE SIGNED (Month, Day, Year) <i>7/15/95</i> | | | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>Jorge J. Acevedo Vilas, MD. 104 Plumtree Rd. Suite #15 Bel Air, Md. 2104</i> | | | | 31. DATE FILED (Month, Day, Year) <i>JUL 19 1995</i> | | | |

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.


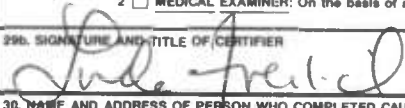

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

95 21699

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|---|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) Helen Delores Hughes | | | | 2. DATE OF DEATH MONTH 07 DAY 17 YEAR 1995 | | 3. TIME OF DEATH 4:11 A M | |
| 4. SOCIAL SECURITY NUMBER 214-76-4518 | | 5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 64 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) Dec. 6 1930 | |
| 9a. FACILITY NAME (If not institution, give street and number) HARFORD Memorial Hospital | | | | 9b. CITY, TOWN OR LOCATION OF DEATH HAVER DE GRACE | | 9c. COUNTY OF DEATH HARFORD | |
| 10a. STATE MARYLAND | | 10b. COUNTY BALTIMORE CO. | | 10c. CITY, TOWN OR LOCATION N/A | | 10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 10e. STREET AND NUMBER 1636 HOPEWELL AVENUE | | | | 10f. ZIP CODE 21221 | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: BLACK | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 6th grade College (1-4 or 5+) | | 15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) DISABLED | | 15b. KIND OF BUSINESS/INDUSTRY UNKNOWN | | | |
| 17. FATHER'S NAME (First, Middle, Last) ALFRED HUGHES | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) MARY ELLEN LYNCH HUGHES | | | |
| 19a. INFORMANT'S NAME (Type/Print) ERBESTINE HUGHES | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1636 HOPEWELL AVENUE, BALTIMORE, MARYLAND 21221 | | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Arbutus Memorial Park 7/21 | | 20c. LOCATION — City or Town, State Baltimore, Maryland | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE  | | | | 22. NAME AND ADDRESS OF FACILITY WILLIAM C. BROWN COMMUNITY F/H 1206 W. North Avenue | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. cerebral palsy DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO | |
| 28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28d. DESCRIBE HOW INJURY OCCURRED | | | |
| 29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  29b. SIGNATURE AND TITLE OF CERTIFIER Linda Freid | | 29c. LICENSE NUMBER 028338 | | 29d. DATE SIGNED (Month, Day, Year) July 18/95 | | | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) LINDA FREID, 181 E. Wheel Road Bel Air 2101 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JUL 19 1995 | | | | 32. REGISTRAR'S SIGNATURE  | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

ITEM: 1. PER MOTHER FILM G-731 1/4/96 t.t

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

| | | | | | | | |
|--|--|---|--|---|--|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last) TOCKLAMUTA TOCKLAMEYA HOWELL | | | | 2. DATE OF DEATH MONTH DAY YEAR JULY 10 1995 | | 3. TIME OF DEATH 5:35 P.M. | |
| 4. SOCIAL SECURITY NUMBER 213-96-0494 | | 5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 18 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) Dec. 1 1976 | |
| 8. BIRTHPLACE (State or Foreign Country) MARYLAND | | | | 9. COUNTY OF DEATH N/A | | | |
| 9a. FACILITY NAME (If not institution, give street and number) SHOCK TRAUMA CENTER | | | | 9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE CITY | | | |
| 10a. STATE MARYLAND | | | | 10b. COUNTY N/A | | 10c. CITY, TOWN OR LOCATION BALTIMORE CITY | |
| 10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | | | | | | |
| 10e. STREET AND NUMBER 23 Norris Street | | | | 10f. ZIP CODE 21223 | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: BLACK | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (9-12) 8th grade College (1-4 or 5+) | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) STUDENT | | 16b. KIND OF BUSINESS/INDUSTRY UNKNOWN | | | |
| 17. FATHER'S NAME (First, Middle, Last) BOBBY WALKER | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) LAVITIA HOWELL | | | |
| 19a. INFORMANT'S NAME (Type/Print) JOSEPH JOHNSON | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1009 W. LAFAYETTE AVENUE, BALTIMORE, MARYLAND 21217 | | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Mt. Zion Cemetery 7/17 | | 20c. LOCATION — City or Town, State BALTIMORE, MARYLAND | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Berkman & Son</i> | | | | 22. NAME AND ADDRESS OF FACILITY WILLIAM C. BROWN COMMUNITY F/H 1206 W. NORTH AVENUE | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → e. Gunshot Wounds to Abdomen and Legs DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. | | | | | | | Approximate Interval Between Onset and Death |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | | | | | | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input checked="" type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) 7/10/95 | | 28b. TIME OF INJURY 1:35 P.M. | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| | | 28d. DESCRIBE HOW INJURY OCCURRED Subject shot | | 28e. LOCATION (Street and Number or Rural Route Number, City or Town, State) STREET 500 GLADE CT. | | | |
| 29a. CERTIFIER (Typed name only) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER <i>J. Laron Locke MD</i> | | | | 29c. LICENSE NUMBER O.C.M.E. | | 29d. DATE SIGNED (Month, Day, Year) JULY 11, 1995 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) J. Laron Locke MD 111 Penn Street, Baltimore, Maryland 21201 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JUL 19 1995 | | | | 32. REGISTRAR'S SIGNATURE <i>John H. ...</i> | | | |

BALTIMORE, MARYLAND 21215-0020




DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 21701

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | |
|---|--|--|--|---|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) HENRY | | | | 2. DATE OF DEATH MONTH Jul DAY 18 YEAR 1995 | | | | 3. TIME OF DEATH 3:49 am M | |
| 4. SOCIAL SECURITY NUMBER 220-24-7996 | | 5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 65 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) Oct. 4, 1929 | | 8. BIRTHPLACE (State or Foreign Country) Maryland | |
| 9a. FACILITY NAME (If not institution, give street and number) Saint Joseph Medical Center | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Towson, Maryland | | | | 9c. COUNTY OF DEATH Baltimore | |
| RESIDENCE OF DECEDENT | | | | | | | | | |
| 10a. STATE Maryland | | 10b. COUNTY Baltimore | | 10c. CITY, TOWN OR LOCATION Essex | | | | 10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 10e. STREET AND NUMBER 215 Antietam Road | | | | 10f. ZIP CODE 21221 | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | | | |
| 11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES 1947-1951 | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White | | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 2 College (1-4 or 5+) 2 | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Engineer | | 16b. KIND OF BUSINESS/INDUSTRY Aero Space | | | | | |
| 17. FATHER'S NAME (First, Middle, Last) Henry Edward Holtschneider | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Nellie Virginia Murphy | | | | | |
| 19a. INFORMANT'S NAME (Type/Print) Betty Holtschneider | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 215 Antietam Rd. Essex, MD. 21221 | | | | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Oak Lawn Cemetery 7/21/1995 | | DATE 7/21/1995 | | 20c. LOCATION — City or Town, State Baltimore, MD. | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE  | | | | 22. NAME AND ADDRESS OF FACILITY Bruzdziński Funeral Home P.A. 1407 Old Eastern Ave. Balt., MD. 21221 | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → CEREBROVASCULAR ACCIDENT Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. | | | | | | | | Approximate Interval Between Onset and Death 12 HOURS | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. CORONARY ARTERY DISEASE | | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/> | | | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | |
| 27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED | |
| 28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| 29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER  | | | | | | 29c. LICENSE NUMBER D 30263 | | 29d. DATE SIGNED (Month, Day, Year) 7-18-95 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) FRANCIS KHOO, MD ST. JOSEPH MEDICAL CENTER TOWSON, MD 21204 | | | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JUL 19 1995 | | | | 32. REGISTRAR'S SIGNATURE  | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

ITEMS: 23 PART I, 27, PER MEO FILM G-727 9/7/95 t.t
ITEM: 29d, PER DR. FILM G-725 7/19/95 t.t

95 21702

1 - FOR
STATE
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|--|--|--|--|
| 1. DECEASED'S NAME (First, Middle, Last) TIMOTHY W. HALL | | | | 2. DATE OF DEATH MONTH 07 DAY 13 YEAR 1995 | | 3. TIME OF DEATH 01:44 A.M. | |
| 4. SOCIAL SECURITY NUMBER 218-84-9854 | | 5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 28 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) Sept 18, 1966 | |
| 8. BIRTHPLACE (State or Foreign Country) North Carolina | | | | 9a. FACILITY NAME (If not Institution, give street and number) 2408 EDMONDSON AVE | | 9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE | |
| 9c. COUNTY OF DEATH n/a | | | | 10a. STATE Maryland | | 10b. COUNTY n/a | |
| 10c. CITY, TOWN OR LOCATION Baltimore | | | | 10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 10e. STREET AND NUMBER 2408 Edmondson Avenue | |
| 10f. ZIP CODE 21223 | | | | 10g. CITIZEN OF WHAT COUNTRY? USA | | 11. MARITAL STATUS 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | |
| 12. WAS DECEASED EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | | | 13. WAS DECEASED OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: Black | |
| 15. DECEASED'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12th Grade College (1-4 or 5+) _____ | | | | 16a. DECEASED'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Vendor | | 16b. KIND OF BUSINESS/INDUSTRY self-employed | |
| 17. FATHER'S NAME (First, Middle, Last) James N. Hall | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Sheilia Russell | | | |
| 19a. INFORMANT'S NAME (Type/Print) Sheilia Russell Sansbury | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9461 Bellhall Drive Baltimore, Maryland 21236 | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Woodlawn Cemetery July 18 | | 20c. LOCATION — City or Town, State Baltimore County, MD | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Gray L. Folger</i> | | | | 22. NAME AND ADDRESS OF FACILITY Nutter Funeral Homes, Inc 2501 Gwynns Falls Parkway Baltimore, Maryland 21216 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. CARDIAC ARRHYTHMIA DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. _____ | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | 29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER <i>Theodore M. King MD</i> | | | | 29c. LICENSE NUMBER O.C.M.E. | | 29d. DATE SIGNED (Month, Day, Year) 7-13-95 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>THEODORE M. KING</i> 111 Penn Street, Baltimore, Maryland 21201 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JUL 19 1995 | | | | 32. REGISTRAR'S SIGNATURE <i>John Buckner-Randall</i> | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the decedent be certified by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR
1 - STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) CHARLES IRELAND | | | | 2. DATE OF DEATH MONTH 7 DAY 17 YEAR 95 | | 3. TIME OF DEATH 2:22 PM | |
| 4. SOCIAL SECURITY NUMBER 217-09-6906 | | 5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 82 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) August 30, 1912 | |
| 9a. FACILITY NAME (If not institution, give street and number) Mercy Hospital | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Baltimore City | | 9c. COUNTY OF DEATH Baltimore City | |
| 10a. STATE Maryland | | | | 10b. COUNTY Baltimore City | | 10c. CITY, TOWN OR LOCATION Baltimore City | |
| 10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | | | 10e. STREET AND NUMBER 118 E. Randall Street | | | |
| 10f. ZIP CODE 21230 | | | | 10g. CITIZEN OF WHAT COUNTRY? United States | | | |
| 11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES World War II | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 9 College (1-4 or 5+) 0 | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Truck Driver | | 16b. KIND OF BUSINESS/INDUSTRY E.I. Kane Company | | | |
| 17. FATHER'S NAME (First, Middle, Last) Richard Thomas Ireland | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Bertha A. Gerbick | | | |
| 19a. INFORMANT'S NAME (Type/Print) John Gorman | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 604 S. Hammonds Ferry Rd. Linthicum, Md. 21090 | | | |
| 20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Metro Crematory, Inc. 7/18/95 | | 20c. LOCATION — City or Town, State Catonsville, Md. | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Harold A. Taylor</i> | | | | 22. NAME AND ADDRESS OF FACILITY McCully Funeral Home 130 E. Fort Ave Baltimore, Md. 21230 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Congestive Heart Failure a. DUE TO (OR AS A CONSEQUENCE OF): Ischemic Cardiomyopathy b. DUE TO (OR AS A CONSEQUENCE OF): Coronary Artery Disease c. DUE TO (OR AS A CONSEQUENCE OF): d. Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER <i>M.D.</i> | | | | 29c. LICENSE NUMBER 06791 | | 29d. DATE SIGNED (Month, Day, Year) 7/17/95 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) MARK KAMINSKI MD 22 S. Green St Baltimore MD 21201 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JUL 19 1995 | | 32. REGISTRAR'S SIGNATURE <i>John A. Randall</i> | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) JOSEPH JOHN JENKINS | | | | 2. DATE OF DEATH MONTH DAY YEAR JULY 17, 1995 | | 3. TIME OF DEATH 13:25 P M | |
| 4. SOCIAL SECURITY NUMBER 216-86-9126 | | 5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 20 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) Feb., 19, 1975 Maryland | |
| 8. BIRTHPLACE (State or Foreign Country) | | | | 9. COUNTY OF DEATH ANNE ARUNDEL | | | |
| 9a. FACILITY NAME (If not institution, give street and number) RT.10 S.B. NORTH OF RT.2 | | | | 9b. CITY, TOWN OR LOCATION OF DEATH N/A | | | |
| 10a. STATE Maryland | | | | 10b. COUNTY Baltimore | | 10c. CITY, TOWN OR LOCATION Riverview | |
| 10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | 10e. STREET AND NUMBER 915 Winsap Court | | 10f. ZIP CODE 21227 | |
| 10g. CITIZEN OF WHAT COUNTRY? United States | | | | 11. MARITAL STATUS 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | |
| 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | | | 14. RACE — American Indian, Black, White, etc. Specify: white | | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 12 | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) helper | | 16b. KIND OF BUSINESS/INDUSTRY liquor delivery | |
| 17. FATHER'S NAME (First, Middle, Last) John C. Jenkins | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Glenda Griffith | | | |
| 19a. INFORMANT'S NAME (Type/Print) Glenda Jenkins | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 915 Winsap Court, Riverview, Maryland 21227 | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Loudon Park Cemetery 7/21 Baltimore, Maryland | | 20c. LOCATION — City or Town, State | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i> | | | | 22. NAME AND ADDRESS OF FACILITY Ambrose Funeral Home of Lansdowne 2719 Hammonds Ferry Road 21227 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. MULTIPLE INJURIES DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) ROAD WAY | | | |
| 27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input checked="" type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide | | | | 28a. DATE OF INJURY (Month, Day, Year) 7 17 95 | | 28b. TIME OF INJURY 1314P M | |
| 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | 28d. DESCRIBE HOW INJURY OCCURRED GUARDRAIL DRIVER OF MOTORCYCLE STRUCK | | 28e. LOCATION (Street and Number or Rural Route Number, City or Town, State) RT 10 ANNE ARUNDEL CO. MD | |
| 29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i> | | | | 29c. LICENSE NUMBER OCME | | 29d. DATE SIGNED (Month, Day, Year) JULY 18, 1995 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) MARYANNE A. KORELL MD 111 Penn Street, Baltimore, Maryland 21201 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JUL 19 1995 | | | | 32. REGISTRAR'S SIGNATURE <i>[Signature]</i> | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 687600

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 5 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 21705

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|---|--|---|--|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last) Junius Johnson | | | | 2. DATE OF DEATH MONTH July DAY 16 YEAR 1995 | | 3. TIME OF DEATH 1230 P.M. | |
| 4. SOCIAL SECURITY NUMBER 251-14 1146 | | 5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 8. AGE (In yrs. last birthday) 82 yrs | | 7. DATE OF BIRTH (Month, Day, Year) 04 09 1913 | |
| 9a. FACILITY NAME (If not institution, give street and number) Baltimore Veteran's Admin Hosp. | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Baltimore, Md. | | 9c. COUNTY OF DEATH Balt. City | |
| RESIDENCE OF DECEDENT | | | | | | | |
| 10a. STATE Maryland | | 10b. COUNTY n/a | | 10c. CITY, TOWN OR LOCATION Baltimore | | 10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | |
| 10e. STREET AND NUMBER 2946 Edmondson Avenue | | | | 10f. ZIP CODE 21229 | | 10g. CITIZEN OF WHAT COUNTRY? USA | |
| 11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES 2/5/44 2/4/46 | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: Black | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 8th College (1-4 or 5+) n/a | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Doorman | | 16b. KIND OF BUSINESS/INDUSTRY Apartments | |
| 17. FATHER'S NAME (First, Middle, Last) William Johnson | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Sylvia Wingate | | | |
| 19a. INFORMANT'S NAME (Type/Print) Dolores Johnson | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2946 Edmondson Ave. Baltimore, MD. 21229 | | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Garrison Forest Vet. Cem. 7/20 | | 20c. LOCATION — City or Town, State Owings Mills, MD. | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Leroy O. Dyett | | | | 22. NAME AND ADDRESS OF FACILITY LEROY O. DYETT & SON FUNERAL HOME 4600 LIBERTY HEIGHTS AVENUE 21207 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Hypercalcemia Due to (or as a consequence of): b. Metastatic Prostate Ca Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | | Approximate Interval Between Onset and Death |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Anemia Diabetes Mellitus | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) N/A | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | | | 28e. PLACE OF INJURY — At home, term, street, factory, office building, etc. (Specify) | | | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | 28g. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER N. Stenley MD Physician | | | | 29c. LICENSE NUMBER MR 0793 | | 29d. DATE SIGNED (Month, Day, Year) 7/16/95 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) VAH 20 Green St, Balt Md 21201-1524 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JUL 19 1995 | | | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 687600 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 21706

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|--|--|---|--|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last) WILLIAM THOMAS KING | | | | 2. DATE OF DEATH MONTH July DAY 13 YEAR 1995 | | 3. TIME OF DEATH 5:06 P M | |
| 4. SOCIAL SECURITY NUMBER 215-07-3132 | | 5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 79 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) Sept 2, 1915 | |
| 9a. FACILITY NAME (If not institution, give street and number) Greater Baltimore Medical Center | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Towson | | 9c. COUNTY OF DEATH Baltimore | |
| 10a. STATE Md | | 10b. COUNTY Baltimore | | 10c. CITY, TOWN OR LOCATION Timonium | | 10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 10e. STREET AND NUMBER 20 CINDER Rd | | | | 10f. ZIP CODE 21093 | | 10g. CITIZEN OF WHAT COUNTRY? USA | |
| 11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES WWII | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: WHITE | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) - | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Contractor | | 16b. KIND OF BUSINESS/INDUSTRY LANDSCAPE | | | |
| 17. FATHER'S NAME (First, Middle, Last) William M. King | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Mary H. Falk | | | |
| 19a. INFORMANT'S NAME (Type/Print) Helen B. King | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20 Cinder Rd Timonium, Md. 21093 | | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) VERNON METHODIST CEM | | DATE 7/17/95 | | 20c. LOCATION — City or Town, State WHITE HALL, Md. | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | | | | 22. NAME AND ADDRESS OF FACILITY EVANS CHAPEL OF MEMORIES - CHIMES 8325 YORK Rd. TIMONIUM, Md. 21093 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → CARDIAC ARREST Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST MYOCARDIAL INFARCT DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | Approximate Interval Between Onset and Death |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| | | 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER | | | | 29c. LICENSE NUMBER 1044560 | | 29d. DATE SIGNED (Month, Day, Year) 7-13-95 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Jeff ALEXANDER M.D. 660 KENILWORTH DR. SUITE 202 Balto, Md 21204 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JUL 19 1995 | | | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 21707

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) JAMES A. Kain | | | | 2. DATE OF DEATH MONTH JULY DAY 14 YEAR 1995 | | 3. TIME OF DEATH 9:05 AM | |
| 4. SOCIAL SECURITY NUMBER 213 02 8502 | | 5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 74 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) JULY 31, 1920 | |
| 8a. FACILITY NAME (If not institution, give street and number) 328 WESTHIRE ROAD | | | | 8b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE | | 8c. COUNTY OF DEATH MARYLAND | |
| 10a. STATE MARYLAND | | 10b. COUNTY BALTIMORE | | 10c. CITY, TOWN OR LOCATION PARKVILLE | | 10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 10e. STREET AND NUMBER 7702 Wilson Ave. | | | | 10f. ZIP CODE 21234 | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES W.W-II | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: WHITE | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 YRS. College (1-4 or 5+) | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) PLUMBER | | 16b. KIND OF BUSINESS/INDUSTRY Union #48 | | | |
| 17. FATHER'S NAME (First, Middle, Last) JAMES Kain | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) MARY KILLEN | | | |
| 19a. INFORMANT'S NAME (Type/Print) RIGINA Kain | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 328 WESTHIRE ROAD | | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) MORRIS MEMORIAL PARK 7-13 | | 20c. LOCATION — City or Town, State PARKVILLE, MARYLAND | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | | | | 22. NAME AND ADDRESS OF FACILITY EVANS CHAPEL OF MEMORIES 8800 HARFORD ROAD - PARKVILLE | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → CIRRHOSIS DUE TO (OR AS A CONSEQUENCE OF): a. b. c. d. Approximate Interval Between Onset and Death | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO | |
| 27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO | |
| | | 28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28e. DESCRIBE HOW INJURY OCCURRED | | | |
| | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | |
| 29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER | | | | 29c. LICENSE NUMBER 037913 | | 29d. DATE SIGNED (Month, Day, Year) JULY 17, 1995 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) DR. RAMON A. SALAS 3447 WILKENS AVE. RM 310 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JUL 19 1995 | | 32. REGISTRAR'S SIGNATURE | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

P.O. BOX 68760

6

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.


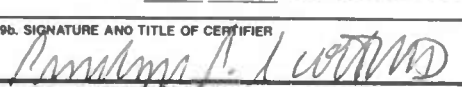

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 21708

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | |
|--|--|--|--|---|--|--|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) WANDA KOLARIK | | | | 2. DATE OF DEATH MONTH July DAY 14 YEAR 1995 | | | | 3. TIME OF DEATH 10:15 p. m. | |
| 4. SOCIAL SECURITY NUMBER 215-03-5482 | | 5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 80 YRS. | | IF UNDER 1 YEAR MONTHS 0 DAYS 0 | | IF UNDER 24 HRS. HOURS 0 MIN. 0 | |
| 7. DATE OF BIRTH (Month, Day, Year) Oct. 21, 1914 | | | | 8. BIRTHPLACE (State or Foreign Country) Maryland | | | | | |
| 9a. FACILITY NAME (If not institution, give street and number) 3649 Lyndale Avenue | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Baltimore | | | | 9c. COUNTY OF DEATH N/A | |
| 10a. STATE Maryland | | | | 10b. COUNTY N/A | | 10c. CITY, TOWN OR LOCATION Baltimore | | | |
| 10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | 10e. STREET AND NUMBER 3649 Lyndale Avenue | | 10f. ZIP CODE 21213 | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | | | 14. RACE — American Indian, Black, White, etc. Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) 8th grade | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Cafeteria Cashier | | | | 16b. KIND OF BUSINESS/INDUSTRY City Schools | |
| 17. FATHER'S NAME (First, Middle, Last) Casimer Taltys | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Julianna Dudek | | | | | |
| 19a. INFORMANT'S NAME (Type/Print) Gerard J. Kolarik (Husband) | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3649 Lyndale Avenue, Baltimore, Md. 21213 | | | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) St. Stanislaus Cem. 7/18/95 | | 20c. LOCATION — City or Town, State Baltimore, Maryland | | | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE  | | | | 22. NAME AND ADDRESS OF FACILITY Schimunek Funeral Home 3331 Brehms Lane, Baltimore, Md. 21213 | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → ACUTE RESPIRATORY INSUFFICIENCY DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST CHRONIC INTERSTITIAL FIBROSIS SYSTEMIC SCLEROSIS | | | | Approximate Interval Between Onset and Death 1-2 d. 5 YRS 7 YRS | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. RENAL INSUFFICIENCY SECONDARY TO SYSTEMIC SCLEROSIS | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/> | | | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 6 <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED | |
| 28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28b. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | 29b. SIGNATURE AND TITLE OF CERTIFIER  | | | | 29c. LICENSE NUMBER D15135 | |
| 29d. DATE SIGNED (Month, Day, Year) 7/17/95 | | | | 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) PENELOPE P. SCOTT M.D. 100 N. BROADWAY BALTIMORE, MD 21231 | | | | | |
| 31. DATE FILED (Month, Day, Year) JUL 19 1995 | | | | 32. REGISTRAR'S SIGNATURE  | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|--|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) LARRY KEYSER | | | | 2. DATE OF DEATH MONTH 07 DAY 14 YEAR 95 | | 3. TIME OF DEATH 08:36A | |
| 4. SOCIAL SECURITY NUMBER 213-76-3252 | | 5. SEX 1 <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 35 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) Oct. 14, 1959 | |
| 8. BIRTHPLACE (State or Foreign Country) Maryland | | | | 9. FACILITY NAME (If not institution, give street and number) University of Md. Hospital | | 10. CITY, TOWN OR LOCATION OF DEATH Baltimore | |
| 11. RESIDENCE OF DECEDENT | | | | 12. COUNTY N/A | | 13. CITY, TOWN OR LOCATION Baltimore | |
| 14. STATE Maryland | | 15. STREET AND NUMBER 1613 Bakbury Ct. | | 16. ZIP CODE 21217 | | 17. CITIZEN OF WHAT COUNTRY? USA | |
| 18. FATHER'S NAME (First, Middle, Last) Thomas Keyser | | 19. MOTHER'S NAME (First, Middle, Maiden Surname) Josephine Jackson | | 20. INFORMANT'S NAME (Type/Print) Josephine Keyser | | 21. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1613 Bakbury Ct, Balto, Md. 21217 | |
| 22. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 23. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) St. Calvary 7/20/95 Balto, Md. | | 24. NAME AND ADDRESS OF FACILITY Joseph L. Russ Funeral Home 2222 W. North Ave. Balto, Md. 21216 | | 25. SIGNATURE OF FUNERAL SERVICE LICENSEE Joseph L. Russ | |
| 26. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Upper GI Bleed DUE TO (OR AS A CONSEQUENCE OF): b. Ruptured esophageal/gastric varices DUE TO (OR AS A CONSEQUENCE OF): c. Cirrhosis DUE TO (OR AS A CONSEQUENCE OF): d. Severe vagulopathy Approximate Interval Between Onset and Death | | | | | | | |
| 27. PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | |
| 28. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | |
| 29. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 30. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 31. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | 32. DATE OF INJURY (Month, Day, Year) | | 33. TIME OF INJURY M | | 34. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 35. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 36. DESCRIBE NOW INJURY OCCURRED | | | | | |
| 37. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| 38. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 39. SIGNATURE AND TITLE OF CERTIFIER Deanne Burton | | | | 40. LICENSE NUMBER D41806 | | 41. DATE SIGNED (Month, Day, Year) 7/14/95 | |
| 42. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) ILEANA GHEORGHIU, M.D. UNIVERSITY of MARYLAND MEDICAL SYSTEM | | | | | | | |
| 43. DATE FILED (Month, Day, Year) JUL 19 1995 | | | | 44. REGISTRAR'S SIGNATURE Jane Davidson-Hardell | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760


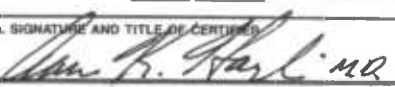

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 3 may be signed by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial/transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|---|--|--|---|
| 1. DECEDENT'S NAME (First, Middle, Last) Gordon Paul Stewart LEAVERTON | | | | 2. DATE OF DEATH MONTH DAY YEAR July 15 1995 | | 3. TIME OF DEATH 5:25 a M | |
| 4. SOCIAL SECURITY NUMBER 213-07-1078 | | 5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 81 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) Sept. 11, 1913 | |
| 8. BIRTHPLACE (State or Foreign Country) Maryland | | | | 9a. CITY, TOWN OR LOCATION OF DEATH Baltimore | | 9c. COUNTY OF DEATH Baltimore | |
| 9b. FACILITY NAME (If not institution, give street and number) Franklin Square Hospital | | | | 10a. STATE Maryland | | 10b. COUNTY Baltimore | |
| 10c. CITY, TOWN OR LOCATION Perry Hall | | | | 10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 10e. STREET AND NUMBER 9908 Forge Park Rd. | |
| 10f. ZIP CODE 21128 | | | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | | 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12th grade College (1-4 or 5+) College (1-4 or 5+) | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Foreman | | 16b. KIND OF BUSINESS/INDUSTRY Steel Company | |
| 17. FATHER'S NAME (First, Middle, Last) John Paul Stewart Leaverton | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Evena Lydia Egeberg | | | |
| 19a. INFORMANT'S NAME (Type/Print) Edith Louise Leaverton (wife) | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9908 Forge Park Rd., Perry Hall, MD 21128 | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Dulaney Valley Mem. Gardens 7/17 | | 20c. LOCATION — City or Town, State Timonium, Maryland | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE  | | | | 22. NAME AND ADDRESS OF FACILITY Schimunek Funeral Homes, Inc. 9705 Belair Rd., Baltimore, MD 21236 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | | Approximate Interval Between Onset and Death |
| a. Pneumonia / Sepsis DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | 1 week |
| b. Aspiration DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | 1 week |
| c. Cardiovascular accident DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | 1 week |
| d. | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Urinary tract infection | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | | | | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/> | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER  | | | | 29c. LICENSE NUMBER RO 1915 | | 29d. DATE SIGNED (Month, Day, Year) 7/15/95 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Dr. Aaron K. Hayashi M.D. 9000 Franklin Square Drive Baltimore Maryland 21237-3998 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JUL 19 1995 | | | | 32. REGISTRAR SIGNATURE  | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760
 BALTIMORE, MARYLAND 21215-0020
 TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital for its records. The funeral director must be notified of the death within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
 TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached and buried with the decedent. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene.
 IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 21711

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|---|--|---|--|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last) ALEX LOWERY | | | | 2. DATE OF DEATH MONTH DAY YEAR JULY 12 1995 | | 3. TIME OF DEATH 0910 M | |
| 4. SOCIAL SECURITY NUMBER N/A | | 5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) YRS. MONTHS DAYS 8 8 8 | | 7. DATE OF BIRTH (Month, Day, Year) July 4, 1995 | |
| 8a. FACILITY NAME (If not institution, give street and number) University Hospital | | | | 8b. CITY, TOWN OR LOCATION OF DEATH Baltimore | | 8c. COUNTY OF DEATH N/A | |
| 9. RESIDENCE OF DECEDENT 10a. STATE Maryland 10b. COUNTY N/A | | | | 10c. CITY, TOWN OR LOCATION Baltimore | | 10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 10e. STREET AND NUMBER 9775 Goodluck Rd. Apt. 7 | | | | 10f. ZIP CODE 20706 | | 10g. CITIZEN OF WHAT COUNTRY? USA | |
| 11. MARITAL STATUS 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: Black | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 0 College (1-4 or 5+) 0 | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) N/A | | 16b. KIND OF BUSINESS/INDUSTRY N/A | | | |
| 17. FATHER'S NAME (First, Middle, Last) Kenneth Elliott Brewer | | | | 18. MOTHER'S NAME (First, Middle, Last) Kaprice Lowery | | | |
| 19a. INFORMANT'S NAME (Type/Print) Kenneth Elliott Brewer | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9775 Goodluck Rd. Apt. 7 Lanham, Md. 20706 | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) St. Zion 7/15/95 | | 20c. LOCATION — City or Town, State Lansdowne, Md. | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Joseph L. Russ | | | | 22. NAME AND ADDRESS OF FACILITY Joseph L. Russ Funeral Home 2222 W. North Ave. Balto, Md. 21216 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → SEPSIS AS A CONSEQUENCE OF NECROTIZING Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST NECROTIZING ENTEROCOLITIS PREMATURITY | | | | | | | Approximate Interval Between Onset and Death 5 DAYS |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 6 <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER Timothy W. Palmer, M.D. | | | | 29c. LICENSE NUMBER D40247 | | 29d. DATE SIGNED (Month, Day, Year) 7/12/95 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Timothy W. Palmer, M.D. 22.s Greene ST BALTO, MD #21201 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JUL 19 1995 | | | | 32. REGISTRAR'S SIGNATURE John D. ... | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 21712

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|---|--|---|--|--|---|
| 1. DECEDENT'S NAME (First, Middle, Last) Helen Marie Mascari | | | | 2. DATE OF DEATH MONTH DAY YEAR July 15 1995 | | 3. TIME OF DEATH 3.20 P M | |
| 4. SOCIAL SECURITY NUMBER 245-12-6547 | | 5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 72 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) Sept. 26, 1922 | |
| 9a. FACILITY NAME (If not institution, give street and number) Bayview Medical Center | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Baltimore | | 9c. COUNTY OF DEATH Baltimore City | |
| 10a. STATE Maryland | | | | 10b. COUNTY | | 10c. CITY, TOWN OR LOCATION Baltimore | |
| 10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | | | | |
| 10e. STREET AND NUMBER 1231 Broening Highway | | | | 10f. ZIP CODE 21224 | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (9-12) 12th Grade College (1-4 or 5+) _____ | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Clerk | | 16b. KIND OF BUSINESS/INDUSTRY Balto. & Ohio Railroad | | | |
| 17. FATHER'S NAME (First, Middle, Last) Fred Suits | | | | 16. MOTHER'S NAME (First, Middle, Maiden Surname) Dorothy Speaks | | | |
| 19a. INFORMANT'S NAME (Type/Print) Geraldine Mason | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 630 Fernhill Road, Baltimore, Maryland 21226 | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Glen Haven Memorial Pk 7-18-95 Glen Bernie, Md. | | 20c. LOCATION — City or Town, State | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Francis S. Karczmarski | | | | 22. NAME AND ADDRESS OF FACILITY McCully Funeral Home 237 Patapsco Vavenue, Baltimore, Md 21225 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Sepsis DUE TO (OR AS A CONSEQUENCE OF): b. Pneumonia DUE TO (OR AS A CONSEQUENCE OF): c. _____ DUE TO (OR AS A CONSEQUENCE OF): d. Throat cancer. | | | | | | | Approximate Interval Between Onset and Death |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/> | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |
| 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DDA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | |
| 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER J. Murray MD Medical Resident | | | | 29c. LICENSE NUMBER 96018 | | 29d. DATE SIGNED (Month, Day, Year) 7-15-95 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) JOSEPH F. MURRAY III MD 6820 N CALVERT ST BALT MD 21202 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JUL 19 1995 | | | | 32. REGISTRAR'S SIGNATURE John Anderson | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

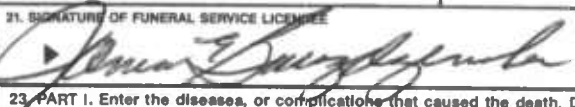
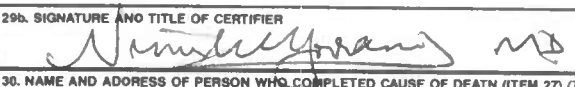
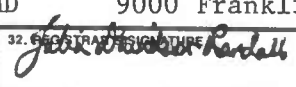
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 21713

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|---|--|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last) Mary MALONE | | | | 2. DATE OF DEATH MONTH DAY YEAR July 15, 1995 | | 3. TIME OF DEATH 5:12 P. M. | |
| 4. SOCIAL SECURITY NUMBER 217-09-7557 | | 5. SEX 1 M 2 F | | 6. AGE (In yrs. last birthday) 76 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) Aug. 18, 1918 | |
| 8. BIRTHPLACE (State or Foreign Country) Maryland | | | | 9a. FACILITY NAME (If not institution, give street and number) Franklin Square Hospital Center | | 9b. CITY, TOWN OR LOCATION OF DEATH Rossville | |
| 9c. COUNTY OF DEATH Baltimore County | | | | 10a. STATE Maryland | | 10b. COUNTY Baltimore | |
| 10c. CITY, TOWN OR LOCATION Essex | | | | 10d. INSIDE CITY LIMITS? 1 YES 2 NO | | 10e. STREET AND NUMBER 1609 Riverwood Road | |
| 10f. ZIP CODE 21221 | | | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | | 11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced | |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES X | | | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 YES 2 NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) Housewife | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Housewife | | 16b. KIND OF BUSINESS/INDUSTRY Own Home | |
| 17. FATHER'S NAME (First, Middle, Last) Harry Bartholow | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Catherine Donohue | | | |
| 19a. INFORMANT'S NAME (Type/Print) Charles Malone | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 111 Riverside Dr. Baltimore, MD 21221 | | | |
| 20a. METHOD OF DISPOSITION 1 Burial 2 Cremation 3 Removal from State 4 Donation 6 Other (Specify) | | | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Oak Lawn Cemetery 7/18/1995 Baltimore, MD. | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE  | | | | 22. NAME AND ADDRESS OF FACILITY Brzezinski Funeral Home P.A. 1407 Eastern Ave. Balt. MD. 21221 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Aspiration Pneumonia DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): Approximate Interval Between Onset and Death 4 Days | | | | | | | PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Cerebrovascular Accident |
| 24a. WAS AN AUTOPSY PERFORMED? 1 YES 2 NO | | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 Inpatient 2 ER/Outpatient 3 DOA OTHER: 4 Nursing Home 5 Residence 6 Other (Specify) | | | | | |
| 27. MANNER OF DEATH 1 Natural 2 Accident 3 Suicide 4 Homicide 5 Pending Investigation 6 Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 YES 2 NO | |
| 28d. DESCRIBE NOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one) 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER  | | | | 29c. LICENSE NUMBER R.D. 1775 | | 29d. DATE SIGNED (Month, Day, Year) 7.18.95 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Nimish Gosrani, MD 9000 Franklin Square Drive Baltimore, MD 21237 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JUL 19 1995 | | | | 32. SIGNATURE OF REGISTRAR  | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

ITEMS: 23 PART I, 27, 28a-f, PER MEO FILM G-725 7/21/95 t.t

21.

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|---|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) KEVIN HUGH MATTHEWS | | | | 2. DATE OF DEATH JUNE 04 1995 | | 3. TIME OF DEATH 10:29 A | |
| 4. SOCIAL SECURITY NUMBER 212-76-7416 | | 5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 38 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) March 18, 1957 | |
| 8. BIRTHPLACE (State or Foreign Country) Maryland | | | | 9a. FACILITY NAME (If not institution, give street and number) WESTMAR high school - in auto | | 9b. CITY, TOWN OR LOCATION OF DEATH Lonaoning | |
| 9c. COUNTY OF DEATH ALLEGHANY | | | | 10a. STATE Maryland | | 10b. COUNTY Allegany | |
| 10c. CITY, TOWN OR LOCATION Lonaoning | | | | 10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 10e. STREET AND NUMBER 6 Beechwood Street | |
| 10f. ZIP CODE 21539 | | | | 10g. CITIZEN OF WHAT COUNTRY? USA | | 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced | |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 0 | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Manager | | 16b. KIND OF BUSINESS/INDUSTRY Auto Parts | |
| 17. FATHER'S NAME (First, Middle, Last) Hugh James Matthews | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Norma Lee Kitzmiller | | | |
| 19a. INFORMANT'S NAME (Type/Print) Mr. Hugh James Matthews | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6 Beechwood St., Lonaoning, Md. 21539 | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Mt. View Cemetery | | 20c. LOCATION — City or Town, State 6/7/95 Moscow Mills, Md. | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE PER DVR JAMES McKENZIE | | | | 22. NAME AND ADDRESS OF FACILITY Eichhorn-McKenzie Funeral Home Lonaoning, Md. 21539 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. ALCOHOL, COCAINE AND NARCOTIC INTOXICATION | | | | | | | |
| DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| b. DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| c. DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| d. DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | | | | |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | | | | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? XX YES 2 <input type="checkbox"/> NO | | | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) AT SCENE | | | |
| 27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input checked="" type="checkbox"/> Could not be determined | | | | 28a. DATE OF INJURY (Month, Day, Year) FOUND: 6-4-95 | | 28b. TIME OF INJURY 8:00 AM | |
| 28c. INJURY AT WORK? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | 28d. DESCRIBE HOW INJURY OCCURRED UNKNOWN | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) FOUND: PARKING LOT | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) LONAONING, MD. | | | | 28g. LOCATION (Street and Number or Rural Route Number, City or Town, State) WESTMAR HIGH SCHOOL | | | |
| 29a. CERTIFIER (Check only one) 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 <input type="checkbox"/> CERTIFYING PHYSICIAN On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER Theodore M. King | | | | 29c. LICENSE NUMBER O.C.M.E. | | 29d. DATE SIGNED (Month, Day, Year) JUNE 05, 1995 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Theodore M. King 111 Penn Street, Baltimore, Maryland 21201 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JUL 19 1995 | | | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 21715

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) MYRTLE LEONA MASON | | | | 2. DATE OF DEATH MONTH JULY DAY 16 YEAR 1995 | | 3. TIME OF DEATH 14:26 P.M. | |
| 4. SOCIAL SECURITY NUMBER 219-30-2397 | | 5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 88 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) Sept 5, 1906 | |
| 9a. FACILITY NAME (If not Institution, give street and number) UNION MEMORIAL HOSPITAL | | | | 9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE CITY | | 9c. COUNTY OF DEATH Balto. City | |
| RESIDENCE OF DECEDENT | | | | | | | |
| 10a. STATE Maryland | | 10b. COUNTY Baltimore City | | 10c. CITY, TOWN OR LOCATION Baltimore | | 10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 10e. STREET AND NUMBER 4405 Grandview Avenue | | | | 10f. ZIP CODE 21211 | | 10g. CITIZEN OF WHAT COUNTRY? USA | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: white | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary (0-12) 8th College (1-4 or 5+) | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Switchboard Operator | | 16b. KIND OF BUSINESS/INDUSTRY Wyman Park Apartment Bldg | | | |
| 17. FATHER'S NAME (First, Middle, Last) Milton Hare | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Estelle Townsley | | | |
| 19a. INFORMANT'S NAME (Type/Print) Joan Bull | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4405 Grandview Avenue Baltimore, MD 21211 | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Woodlawn Cemetery | | DATE 7/20 | | 20c. LOCATION — City or Town, State Woodlawn, Maryland | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Joey Henss</i> | | | | 22. NAME AND ADDRESS OF FACILITY Burgee-Henss Funeral Home 3631 Falls Road Baltimore, MD 21211 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | | a. SMALL BOWEL INFARCTION WITH SEPSIS | | | | | Approximate Interval Between Onset and Death 1 DAY |
| | | b. THROMBOSIS OF SUPERIOR MESENTERIC ARTERY | | | | | 1 DAY |
| | | c. GENERALIZED ARTERIOSCLEROSIS | | | | | YEARS |
| | | d. | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. CARCINOMA OF THE COLON | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| | | 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER Charles E. Brown, M.D. Assoc. Pathologist | | | | 29c. LICENSE NUMBER DO1008 | | 29d. DATE SIGNED (Month, Day, Year) JULY 17, 1995 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) CHARLES E. BROWN, M.D. 200 E. UNIV. PARKWAY BALTO., MD - 21218 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JUL 19 1995 | | | | 32. REGISTRAR'S SIGNATURE <i>John D. ...</i> | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 21716

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|---|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) EDITH GREEN McDONALD | | | | 2. DATE OF DEATH MONTH 7 DAY 14 YEAR 1995 | | 3. TIME OF DEATH 5:30 A M | |
| 4. SOCIAL SECURITY NUMBER 213-28-9457 | | 5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F | 6. AGE (In yrs. last birthday) 64 YRS. | IF UNDER 1 YEAR MONTHS 0 DAYS 0 | IF UNDER 24 HRS. HOURS 0 MIN. 0 | 7. DATE OF BIRTH (Month, Day, Year) 1/19/31 | |
| 9a. FACILITY NAME (If not institution, give street and number) #28 N. Mount Street (res.) | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Baltimore | | 9c. COUNTY OF DEATH n/a | |
| 10a. STATE Maryland | | | | 10b. COUNTY n/a | | 10c. CITY, TOWN OR LOCATION Baltimore | |
| 10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | | | 10e. STREET AND NUMBER #28 N. Mount Street | | | |
| 10f. ZIP CODE 21223 | | | | 10g. CITIZEN OF WHAT COUNTRY? USA | | | |
| 11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: Black | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12th | | 15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Maintenance | | 15b. KIND OF BUSINESS/INDUSTRY Race Track | | | |
| 17. FATHER'S NAME (First, Middle, Last) STEWART GREEN | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Mary Fitzhugh | | | |
| 19a. INFORMANT'S NAME (Type/Print) ANN SAUNDERS | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8325 WESTERN WIND CIRCLE, BALTO., MD 21244 | | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) LOUDON PARK CEMETERY | | 20c. LOCATION — City or Town, State BALTIMORE, MARYLAND | | 20d. DATE | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i> | | | | 22. NAME AND ADDRESS OF FACILITY HEROY O. DYETT & SON FUNERAL HOME 4600 LIBERTY HEIGHTS AVENUE 21207 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. RENAL CANCER DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): Approximate interval Between Onset and Death | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | | | | |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | | | | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | 28g. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i> | | | | 29c. LICENSE NUMBER D29071 | | 29d. DATE SIGNED (Month, Day, Year) 7-14-95 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) R. KRISHNAN, MD 821 N. EUTAW ST #305 BALTIMORE MD 21201 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JUL 19 1995 | | | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) HELEN BERTHA PIERSON | | | | 2. DATE OF DEATH MONTH JULY DAY 17, YEAR 1995 | | 3. TIME OF DEATH 11:30 P.M. | |
| 4. SOCIAL SECURITY NUMBER 155-36-4734 | | 5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 99 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 08-01-1895 | |
| 9a. FACILITY NAME (If not institution, give street and number) COLLEGE MANOR, INC. | | | | 9b. CITY, TOWN OR LOCATION OF DEATH LUTHERVILLE | | 9c. COUNTY OF DEATH BALTIMORE | |
| RESIDENCE OF DECEDENT | | | | | | | |
| 10a. STATE MARYLAND | | 10b. COUNTY ANNE ARUNDEL | | 10c. CITY, TOWN OR LOCATION GIBSON ISLAND | | 10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| 10e. STREET AND NUMBER 658 ROUND HILL ROAD | | | | 10f. ZIP CODE 21056 | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: WHITE | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) N/A | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) HOMEMAKER | | 16b. KIND OF BUSINESS/INDUSTRY OWN HOME | | | |
| 17. FATHER'S NAME (First, Middle, Last) VALERE PRETOT | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) FANNY GENERET | | | |
| 19a. INFORMANT'S NAME (Type/Print) ADELE P. ALEXANDER | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) P.O. BOX 102, GIBSON ISLAND 21056 | | | |
| 20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) HILLTOP SERVICES, INC. 7/19/1995 | | 20c. LOCATION — City or Town, State TOWSON, MARYLAND | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>R. George Hopkins</i> | | | | 22. NAME AND ADDRESS OF FACILITY SINGLETON FUNERAL HOME, 1 SECOND AVENUE, S.W. GLEN BURNIE, MARYLAND 21061 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | | a. <i>Renal failure</i> DUE TO (OR AS A CONSEQUENCE OF): | | | | Approximate Interval Between Onset and Death <i>2 wks</i> | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST | | b. <i>Arteriosclerotic heart disease</i> DUE TO (OR AS A CONSEQUENCE OF): | | | | 25 y | |
| | | c. <i>Aortic stenosis</i> DUE TO (OR AS A CONSEQUENCE OF): | | | | 25 y | |
| | | d. | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | | | 28e. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER <i>Norman R. Freeman MD</i> | | | | 29c. LICENSE NUMBER D02001 | | 29d. DATE SIGNED (Month, Day, Year) 7/19/95 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (Item 27) (Type, Print) NORMAN R. FREEMAN JR - 4300 N. Charles St - Baltimore Md | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JUL 19 1995 | | | | 32. REGISTRAR'S SIGNATURE <i>Jane Anderson</i> | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|---|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) <i>James F. Parker, Jr</i> | | | | 2. DATE OF DEATH MONTH <i>7</i> DAY <i>17</i> YEAR <i>95</i> | | 3. TIME OF DEATH <i>2:00A M</i> | |
| 4. SOCIAL SECURITY NUMBER <i>214-26-0702</i> | | 5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) <i>66</i> YRS. | | 7. DATE OF BIRTH (Month, Day, Year) <i>OCT 25, 1928</i> | |
| 9a. FACILITY NAME (If not institution, give street and number) <i>2919 Virginia Avenue</i> | | | | 9b. CITY, TOWN OR LOCATION OF DEATH <i>Baltimore</i> | | 9c. COUNTY OF DEATH <i>NA</i> | |
| 10a. STATE <i>Md</i> | | | | 10b. COUNTY <i>NA</i> | | 10c. CITY, TOWN OR LOCATION <i>Baltimore</i> | |
| 10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | | | 10e. STREET AND NUMBER <i>2919 Virginia Ave</i> | | | |
| 10f. ZIP CODE <i>21215</i> | | | | 10g. CITIZEN OF WHAT COUNTRY? <i>U.S.A</i> | | | |
| 11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES <i>10-23-50 1023-1952</i> | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: <i>Black</i> | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <i>10th grade</i> College (13-16 or 17+) <i>NA</i> | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <i>Checker</i> | | 16b. KIND OF BUSINESS/INDUSTRY <i>Bethlehem Steel</i> | |
| 17. FATHER'S NAME (First, Middle, Last) <i>James Parker, Sr</i> | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) <i>Rachel Bunch</i> | | | |
| 19a. INFORMANT'S NAME (Type/Print) <i>Kathleen Parker</i> | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>2919 Virginia Avenue Baltimore Md 21215</i> | | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <i>Garrison Forest Vet 11/20/95</i> | | 20c. LOCATION — City or Town, State <i>Darings Mills, Md</i> | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Dale March</i> | | | | 22. NAME AND ADDRESS OF FACILITY <i>March F.H. West 4300 Wabash Ave Baltimore 21215</i> | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Seizure disorder</i> | | | | | | | |
| Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | | |
| a. <i>Alcoholism</i> | | | | | | | |
| b. <i>Due to (or as a consequence of):</i> | | | | | | | |
| c. <i>Due to (or as a consequence of):</i> | | | | | | | |
| d. <i>Due to (or as a consequence of):</i> | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO | | | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input checked="" type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M <input type="checkbox"/> YES <input type="checkbox"/> NO | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO | |
| 28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28d. DESCRIBE HOW INJURY OCCURRED | | | | | |
| 28e. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | |
| 29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER <i>Robert H. Roby</i> | | | | 29c. LICENSE NUMBER <i>037728</i> | | 29d. DATE SIGNED (Month, Day, Year) <i>7/17/95</i> | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>Robert Kenneth Roby MD 2435 W Belvedere Ave Baltimore MD 21215</i> | | | | | | | |
| 31. DATE FILED (Month, Day, Year) <i>JUL 19 1995</i> | | 32. REGISTRY SIGNATURE <i>Julia A. Russell-Randall</i> | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

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95 21719

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|--|--|--|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) WALTER JOSEPH POREMSKI | | | | 2. DATE OF DEATH MONTH 07 DAY 11 YEAR 95 | | 3. TIME OF DEATH 11:15 AM | |
| 4. SOCIAL SECURITY NUMBER 216-36-1841 | | 5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 56 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 11-20-38 | |
| 8. FACILITY NAME (If not institution, give street and number) 810 S. ROSE STREET | | | | 9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE | | 9c. COUNTY OF DEATH N/A | |
| 10a. STATE MARYLAND | | | | 10b. COUNTY N/A | | 10c. CITY, TOWN OR LOCATION BALTIMORE | |
| 10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | 10e. STREET AND NUMBER 810 S. ROSE STREET | | 10f. ZIP CODE 21224 | |
| 10g. CITIZEN OF WHAT COUNTRY? USA | | | | 11. MARITAL STATUS 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES ARMY | |
| 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | | | 14. RACE — American Indian, Black, White, etc. Specify: WHITE | | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (9-12) 12 YEARS College (1-4 or 5+) College (1-4 or 5+) | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) WELDER | | 16b. KIND OF BUSINESS/INDUSTRY LENDERKING | |
| 17. FATHER'S NAME (First, Middle, Last) WALTER POREMSKI | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Unknown SKOPP | | | |
| 19a. INFORMANT'S NAME (Type/Print) MRS. MARIE POREMSKI | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 810 S. ROSE STREET BALTO. MD. 21224 | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) ST. STANISLAUS CEMETERY 7-14 BALTO. MD. | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Charles R. Hozzowski</i> | | | | 22. NAME AND ADDRESS OF FACILITY KACZOROWSKI FUNERAL HOME 2525 FLEET ST. BALTO. MD. 21224 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. METASTATIC CANCER OF LUNG DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. | | | | | | | Approximate Interval Between Onset and Death |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | | | | DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/> |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 28d. DESCRIBE NOW INJURY OCCURRED | | | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) HOME | | | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | 28g. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER N SARAF N Saraf | | | | 29c. LICENSE NUMBER D45186 | | 29d. DATE SIGNED (Month, Day, Year) 7/17/95 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) NIRMALA SARAF | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JUL 19 1995 | | | | 32. REGISTRAR'S SIGNATURE <i>Johanna K. Carroll</i> | | | |

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

6 + 1

95-4147-510
B.K.S

95 21720


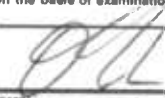
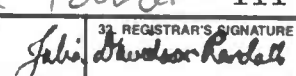
ITEMS: 23 PART I, 27, 28a-f, PER MEO FILM 8/1/95 t.t

6-726

1. FOR
STATE
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|---|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) ROBERT C. PODOWSKI | | | | 2. DATE OF DEATH MONTH JULY DAY 16 YEAR 1995 | | 3. TIME OF DEATH 1303 P M | |
| 4. SOCIAL SECURITY NUMBER 215-68-3444 | | 5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 39 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) July 13, 1956 | |
| 8. BIRTHPLACE (State or Foreign Country) Maryland | | 9a. FACILITY NAME (If not institution, give street and number) 26TH AND HAMPDEN AVENUE | | 9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE CITY | | 9c. COUNTY OF DEATH N/A | |
| 10a. STATE Maryland | | 10b. COUNTY Baltimore City | | 10c. CITY, TOWN OR LOCATION Baltimore | | 10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input type="checkbox"/> NO | |
| 10e. STREET AND NUMBER 2623 Hampden Avenue | | | | 10f. ZIP CODE 21211 | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Salesperson | | 16b. KIND OF BUSINESS/INDUSTRY Floor Covering | | | |
| 17. FATHER'S NAME (First, Middle, Last) Edward Anthony Podowski | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Theresa Mary Szymanik | | | |
| 19a. INFORMANT'S NAME (Type/Print) Diana Podowski | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2623 Hampden Avenue, Baltimore, Maryland 21211 | | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Dulaney Valley Mem Grdns 7/19 | | 20c. LOCATION — City or Town, State Cockeysville, MD | | 21. SIGNATURE OF FUNERAL SERVICE LICENSEE  | |
| 22. NAME AND ADDRESS OF FACILITY Burgee-Henss Funeral Home 3631 Falls Road Baltimore, MD 21211 | | 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. PROPOXYPHENE AND ALCOHOL INTOXICATION COMPLICATED BY HEAT EXPOSURE DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | 24a. WAS AN AUTOPSY PERFORMED? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | | | | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) INSIDE OF TRUCK | |
| 27. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input checked="" type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) FOUND ON 7/16/95 | | 28b. TIME OF INJURY 12:45 PM | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 28d. DESCRIBE NOW INJURY OCCURRED UNKNOWN | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) FOUND AT HOME | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) 2623 HAMPDEN AVE. BALTIMORE, MD. | | | |
| 29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER  | | | | 29c. LICENSE NUMBER O.C.M.E | | 29d. DATE SIGNED (Month, Day, Year) JULY 17, 1995 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) David R Fowler 111 Penn Street, Baltimore, Maryland 21201 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JUL 19 1995 | | 32. REGISTRAR'S SIGNATURE  | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95-4133-510

blh

95 21721

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|---|--|--|---|
| 1. DECEDENT'S NAME (First, Middle, Last) Michael Rosenberg | | | | 2. DATE OF DEATH MONTH DAY YEAR July 15 1995 | | 3. TIME OF DEATH 1701 M | |
| 4. SOCIAL SECURITY NUMBER 219-82-9723 | | 5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 33 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) FEB 20 1962 | |
| 8. BIRTHPLACE (State or Foreign Country) MARYLAND | | | | 9a. FACILITY NAME (If not institution, give street and number) Good Samaritan Hospital | | 9b. CITY, TOWN OR LOCATION OF DEATH Baltimore | |
| 9c. COUNTY OF DEATH | | | | 10a. STATE MARYLAND | | 10b. COUNTY Baltimore | |
| 10c. CITY, TOWN OR LOCATION PARKVILLE | | | | 10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 10e. STREET AND NUMBER 18 Hinesleigh Court | |
| 10f. ZIP CODE 21234 | | | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | | 11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: WHITE | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 YRS. College (1-4 or 5+) College | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) SELF EMP - owner | | 16b. KIND OF BUSINESS/INDUSTRY MR. CARPET STORE | |
| 17. FATHER'S NAME (First, Middle, Last) STEPHEN DAVID ROSENBERG | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) HARRIET SALGANIK | | | |
| 19a. INFORMANT'S NAME (Type/Print) LAURA M. ROSENBERG | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 18 Hinesleigh Court PARKVILLE, MARYLAND 21234 | | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) HOLY ROSARY CEMETERY 7-18 | | 20c. LOCATION — City or Town, State DUNDALK, MARYLAND | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | | | | 22. NAME AND ADDRESS OF FACILITY EVANS CHAPEL OF MEMORIES 8800 HARFORD ROAD - PARKVILLE | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. | | | | | | | Approximate Interval Between Onset and Death |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO | | | | | | | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER | | | | 29c. LICENSE NUMBER O.C.M.E. | | 29d. DATE SIGNED (Month, Day, Year) July 16 1995 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) MARIO F. GOLUB MD 111 Penn Street, Baltimore, Maryland 21201 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JUL 19 1995 | | 32. REGISTRAR'S SIGNATURE | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

12

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 21722

Item 10e, g-725, 7-19-95, perf. h., dk

Film G, 725, item #8, 19a, 7/24/95, cyw

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) Joyce G. Randle | | | | 2. DATE OF DEATH MONTH 7 DAY 15 YEAR 95 | | 3. TIME OF DEATH 12:07 AM | |
| 4. SOCIAL SECURITY NUMBER 227-42-4986 | | 5. SEX 1 <input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 60 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 10-3-34 | |
| 8. FACILITY NAME (If not institution, give street and number) Inns of Enclave NW-2525 W Belvidere | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Baltimore | | 9c. COUNTY OF DEATH MD | |
| 10a. STATE MD | | 10b. COUNTY NA | | 10c. CITY, TOWN OR LOCATION Baltimore | | 10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES <input type="checkbox"/> NO | |
| 10e. STREET AND NUMBER 2532 Edgewood Circle North | | | | 10f. ZIP CODE 21215 | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: Black | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12th grade College (1-4 or 5+) NA | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Housewife | | 16b. KIND OF BUSINESS/INDUSTRY Home | |
| 17. FATHER'S NAME (First, Middle, Last) Herman Given | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Nancy Brown | | | |
| 19a. INFORMANT'S NAME (Type/Print) Ronald Randle | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 926 Coleridge Road Baltimore 21229 | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Garrison Forest Veterans Burial Home | | 20c. LOCATION — City or Town, State Dwight Mills, MD | | 20d. DATE 7/15/95 | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Sala March | | | | 22. NAME AND ADDRESS OF FACILITY March F.H. West 4300 Wabash Avenue Baltimore 21215 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → RESPIRATORY FAILURE Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST RENAL FAILURE HYPERTENSION DIABETES MELLITUS | | | | | | | Approximate Interval Between Onset and Death 2 years 4 months |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. UTERINE TUMOR. | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | | | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 6 <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER Cosmo Jacobs MD | | | | 29c. LICENSE NUMBER D21328 | | 29d. DATE SIGNED (Month, Day, Year) 7 18 95 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Cosmo Jacobs 4001 Liberty Heights Ave Baltimore MD 21207 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JUL 19 1995 | | | | 32. REGISTRAR'S SIGNATURE Jane Anderson-Randall | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be required by the attending physician and completely filled in by the funeral director, page 5 should be attached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified in writing.

RECEIVED
JAN 10 1964

RECEIVED
JAN 10 1964

95 21723

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|--|--|--|--|--|---|
| 1. DECEDENT'S NAME (First, Middle, Last) FRANCES C. RADZISZEWSKI | | | | 2. DATE OF DEATH MONTH DAY YEAR July 14, 1995 | | 3. TIME OF DEATH 6:00 A M | |
| 4. SOCIAL SECURITY NUMBER 223-32-5044 | | 5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 81 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) Feb. 16, 1914 | |
| 8. BIRTHPLACE (State or Foreign Country) Virginia | | | | 9a. FACILITY NAME (If not institution, give street and number) Harbor Hospital Center | | 9b. CITY, TOWN OR LOCATION OF DEATH Baltimore City | |
| 9c. COUNTY OF DEATH NA | | | | 10a. STATE Maryland | | | |
| 10b. COUNTY NA | | | | 10c. CITY, TOWN OR LOCATION Baltimore (Curtis Bay) | | | |
| 10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | | | 10e. STREET AND NUMBER 1604 Elmtree Street | | | |
| 10f. ZIP CODE 21226 | | | | 10g. CITIZEN OF WHAT COUNTRY? USA | | | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 6 College (1-4 or 5+) 6 | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Homemaker | | 16b. KIND OF BUSINESS/INDUSTRY Housewife | |
| 17. FATHER'S NAME (First, Middle, Last) Unknown Pollard | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Unknown | | | |
| 19a. INFORMANT'S NAME (Type/Print) Mr. Frank A. Radziszewski | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1604 Elmtree St., Baltimore, Maryland 21226 | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Cedar Hill Cemetery July 17, '95 Baltimore, Maryland | | 20c. LOCATION — City or Town, State | | 20d. DATE | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Kevin E. Ecker | | | | 22. NAME AND ADDRESS OF FACILITY McCully Funeral Home of Brooklyn 237 E. Patapsco Ave., Balto., Md. 21225 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <u>Pneumonia</u> DUE TO (OR AS A CONSEQUENCE OF): b. <u>Lung Cancer</u> DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | | Approximate Interval Between Onset and Death |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>Diabetes Mellitus</u> <u>Hypertension</u> | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | | | | DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/> |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER <u>Kevin E. Ecker</u> House Staff | | | | 29c. LICENSE NUMBER AS2441616-11 | | 29d. DATE SIGNED (Month, Day, Year) July 14 th 1995 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Dr. Sridhar. Atluri, Harbor Hosp. Center, 3001 S. Hanover St. Baltimore MD 21225 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JUL 19 1995 | | | | 32. REGISTRAR'S SIGNATURE <u>Johi D. ...</u> | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 21724

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|--|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) MICHAEL D. RILEY | | | | 2. DATE OF DEATH MONTH 07 DAY 17 YEAR 95 | | 3. TIME OF DEATH 11:10 PM | |
| 4. SOCIAL SECURITY NUMBER 216-50-2044 | | 5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 46 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) Mar. 9 1949 | |
| 8. BIRTHPLACE (State or Foreign Country) MARYLAND | | | | 9a. FACILITY NAME (If not institution, give street and number) UNIVERSITY HOSPITAL | | 9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE CITY | |
| 9c. COUNTY OF DEATH N/A | | | | 10a. STATE MARYLAND | | 10b. COUNTY N/A | |
| 10c. CITY, TOWN OR LOCATION BALTIMORE CITY | | | | 10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | 10e. STREET AND NUMBER 1732 LAFAYETTE AVENUE | |
| 10f. ZIP CODE 21217 | | | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | | 11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: BLACK | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 10th grade College (1-4 or 5+) PIPFITTER | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) BETH STEEL SHIP YARD | | 16b. KIND OF BUSINESS/INDUSTRY | |
| 17. FATHER'S NAME (First, Middle, Last) JAMES LEIGHTON | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) MABEL LEIGHTON | | | |
| 19a. INFORMANT'S NAME (Type/Print) VONDA LEIGHTON | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1018 N. Woodington Rd., Baltimore, Maryland 21229 | | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Western Star Cemetery 7/21 | | 20c. LOCATION — City or Town, State Baltimore, Maryland | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | | | | 22. NAME AND ADDRESS OF FACILITY WILLIAM C. BROWN COMMUNITY F/H 1206 W. North Avenue | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → PNEUMONIA | | | | | | | |
| DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | | |
| DUE TO (OR AS A CONSEQUENCE OF): AIDS | | | | | | | |
| DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | | | | |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO | | | | | | | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | |
| 27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | |
| 28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO | | | | 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER | | | | 29c. LICENSE NUMBER MR0715 | | 29d. DATE SIGNED (Month, Day, Year) 7/17/95 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) MICHELLE YOUNG UNIVERSITY HOSPITAL BALTIMORE | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JUL 19 1995 | | | | 32. REGISTRAR'S SIGNATURE | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

P.O. BOX 68760

4

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 21725

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) Frederick F. Ravadge Sr. | | | | 2. DATE OF DEATH MONTH DAY YEAR July 14 1995 | | 3. TIME OF DEATH 7:30 P M | |
| 4. SOCIAL SECURITY NUMBER 214-26-1932 | | 5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 64 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) July 21, 1930 | |
| 8. BIRTHPLACE (State or Foreign Country) Maryland | | | | 9a. FACILITY NAME (If not institution, give street and number) 566 Cardinal Drive | | 9b. CITY, TOWN OR LOCATION OF DEATH Pasadena | |
| 9c. COUNTY OF DEATH Anne Arundel | | | | 10a. STATE Maryland | | 10b. COUNTY Anne Arundel | |
| 10c. CITY, TOWN OR LOCATION Pasadena | | | | 10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 10e. STREET AND NUMBER 566 Cardinal Drive | |
| 10f. ZIP CODE 21122 | | | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | | 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced | |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES 1947-48 | | | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No - If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE - American Indian, Black, White, etc. Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 2 | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Teacher | | 16b. KIND OF BUSINESS/INDUSTRY Machine Shop | |
| 17. FATHER'S NAME (First, Middle, Last) John Frederick Ravadge | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Agnes Rudel | | | |
| 19a. INFORMANT'S NAME (Type/Print) David Ravadge | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 209 Magothy Beach Road, Pasadena, Maryland 21122 | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Glen Haven Memorial Park 7-18-95 | | 20c. LOCATION - City or Town, State Glen Bernie, Maryland | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i> Funeral Director | | | | 22. NAME AND ADDRESS OF FACILITY 3204 Mountain Road, Pasadena McCully Funeral Home of Pasadena Md. 21122 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <i>metastatic renal cell carcinoma</i> DUE TO (OR AS A CONSEQUENCE OF): b. <i>Pulmonary metastases</i> DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. PLACE OF INJURY - At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i> (Attending physician) | | | | 29c. LICENSE NUMBER MD. D32353 | | 29d. DATE SIGNED (Month, Day, Year) 7/17/95 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Daniel J. Konick, M.D. 180 Adm. Cochran Dr., Annapolis, MD 21401 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JUL 19 1995 | | 32. REGISTRAR'S SIGNATURE <i>[Signature]</i> | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 21726

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) <i>Charles E. Spigel mire</i> | | | | 2. DATE OF DEATH MONTH DAY YEAR <i>July 15, 1995</i> | | 3. TIME OF DEATH <i>00:45 A M</i> | |
| 4. SOCIAL SECURITY NUMBER <i>214-10-2014</i> | | 5. SEX <i>1 M 2 F</i> | | 6. AGE (In yrs. last birthday) <i>89</i> YRS. | | 7. DATE OF BIRTH (Month, Day, Year) <i>Jan. 06, 1906</i> | |
| 8. BIRTHPLACE (State or Foreign Country) <i>OHIO</i> | | | | 9. COUNTY OF DEATH <i>City</i> | | | |
| 10. FACILITY NAME (If not institution, give street and number) <i>Deaton Medical Center</i> | | | | 11. CITY, TOWN OR LOCATION OF DEATH <i>Baltimore</i> | | 12. COUNTY OF DEATH <i>City</i> | |
| 13. RESIDENCE OF DECEDENT | | | | 14. CITY, TOWN OR LOCATION | | | |
| 15. STATE <i>Maryland</i> | | 16. COUNTY <i>Baltimore</i> | | 17. CITY, TOWN OR LOCATION <i>Catonsville</i> | | 18. INSIDE CITY LIMITS? <i>1 YES 2 NO</i> | |
| 19. STREET AND NUMBER <i>719 Maiden Choice Lane, BLDG 1, #1206</i> | | | | 20. ZIP CODE <i>21228</i> | | 21. CITIZEN OF WHAT COUNTRY? <i>USA</i> | |
| 22. MARITAL STATUS <i>1 Never Married 2 Married 3 Widowed 4 Divorced</i> | | 23. WAS DECEDENT EVER IN U.S. ARMED FORCES? <i>1 YES 2 NO</i> IF YES, GIVE WAR OR DATES | | 24. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <i>1 YES 2 NO</i> Specify: | | 25. RACE — American Indian, Black, White, etc. Specify: <i>White</i> | |
| 26. DECEDENT'S EDUCATION (Specify only highest grade completed) <i>Elementary/Secondary (0-12) 4</i> | | 27. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <i>Pharmacist</i> | | 28. KIND OF BUSINESS/INDUSTRY <i>Drug Company</i> | | | |
| 29. FATHER'S NAME (First, Middle, Last) <i>Charles Spigel mire, Sr.</i> | | | | 30. MOTHER'S NAME (First, Middle, Maiden Surname) <i>Mary Katherine Sheekey</i> | | | |
| 31. INFORMANT'S NAME (Type/Print) <i>Josephine Spigel mire</i> | | | | 32. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>Catonsville, 719 Maiden Choice Lane, Bldg 1 #1206 MD 21228</i> | | | |
| 33. METHOD OF DISPOSITION <i>1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)</i> | | 34. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <i>Sacred Heart of Mary 7/19</i> | | 35. LOCATION — City or Town, State <i>Dundalk, MD</i> | | | |
| 36. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Joseph L. Klug</i> | | | | 37. NAME AND ADDRESS OF FACILITY <i>HUBBARD FUNERAL HOME, INC. 4107 Wilkens Ave, Baltimore, MD 21229</i> | | | |
| 38. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Pneumonia</i> | | | | | | | |
| DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | | |
| b. <i>prolonged tracheostomy</i> | | | | | | | |
| DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| c. <i>Due to (OR AS A CONSEQUENCE OF):</i> | | | | | | | |
| d. <i>Due to (OR AS A CONSEQUENCE OF):</i> | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Atherosclerotic Cardiovascular disease</i> <i>old Cerebro Vascular accident</i> | | | | | | | |
| 39. WAS AN AUTOPSY PERFORMED? <i>1 YES 2 NO</i> | | 40. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <i>1 YES 2 NO</i> | | | | | |
| 41. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | |
| 42. WAS CASE REFERRED TO MEDICAL EXAMINER? <i>1 YES 2 NO</i> | | 43. PLACE OF DEATH (Check only one) HOSPITAL: <i>1 Inpatient 2 ER/Outpatient 3 DOA</i> OTHER: <i>4 Nursing Home 5 Residence 6 Other (Specify)</i> | | | | | |
| 44. MANNER OF DEATH <i>1 Natural 2 Accident 3 Suicide 4 Homicide 5 Pending Investigation 6 Could not be determined</i> | | 45. DATE OF INJURY (Month, Day, Year) | | 46. TIME OF INJURY <i>M</i> | | 47. INJURY AT WORK? <i>1 YES 2 NO</i> | |
| 48. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 49. DESCRIBE NOW INJURY OCCURRED | | | | | |
| 50. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | 51. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | |
| 52. CERTIFIER (Check only one) <i>1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.</i> <i>2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.</i> | | | | | | | |
| 53. SIGNATURE AND TITLE OF CERTIFIER <i>Joseph L. Klug, MD (House physician)</i> | | | | 54. LICENSE NUMBER <i>D45148</i> | | 55. DATE SIGNED (Month, Day, Year) <i>July 15, 1995</i> | |
| 56. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>Kicordo Osorno, MD Deaton Specialty Hospital & Home</i> | | | | | | | |
| 57. DATE FILED (Month, Day, Year) <i>JUL 19 1995</i> | | 58. REGISTRAR'S SIGNATURE <i>John Andrew Karkoff</i> | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 21727

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|--|--|---|--|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last) ELIZABETH SHRIVER | | | | 2. DATE OF DEATH MONTH DAY YEAR JULY 17 1995 | | 3. TIME OF DEATH 6:45 P M | |
| 4. SOCIAL SECURITY NUMBER 220-22-1662 | | 5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 94 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) AUG 10, 1900 | |
| 9a. FACILITY NAME (If not institution, give street and number) FREDERICK VILLA NSG. CTR. | | | | 9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE | | 9c. COUNTY OF DEATH BALTIMORE | |
| RESIDENCE OF DECEDENT | | | | | | | |
| 10a. STATE Maryland | | 10b. COUNTY Baltimore | | 10c. CITY, TOWN OR LOCATION Baltimore | | 10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| 10e. STREET AND NUMBER 913 Circle Drive | | | | 10f. ZIP CODE 21227 | | 10g. CITIZEN OF WHAT COUNTRY? USA | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 6 College (1-4 or 5+) 6 | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) examiner | | 16b. KIND OF BUSINESS/INDUSTRY Montgomery Ward | | | |
| 17. FATHER'S NAME (First, Middle, Last) William HAMILTON | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Marjorie MUIR | | | |
| 19a. INFORMANT'S NAME (Type/Print) John G. Vorlauffer | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1004 Oak Grove Lane, Falling Waters, WV 25419 | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Loudon Park Cemetery | | DATE 7-21 | | 20c. LOCATION — City or Town, State Baltimore, MD | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Jackie H. Shannon | | | | 22. NAME AND ADDRESS OF FACILITY HUBBARD FUNERAL HOME, INC. 4107 Wilkens Ave, Baltimore, MD 21229 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Congestive heart failure DUE TO (OR AS A CONSEQUENCE OF): b. Mitral regurgitation DUE TO (OR AS A CONSEQUENCE OF): c. Coronary artery disease DUE TO (OR AS A CONSEQUENCE OF): d. Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | | Approximate interval between Onset and Death 7 years |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Malnutrition, Dementia, Anemia | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | | | | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER Bruce N. McCurdy MD Attending Phy | | | | 29c. LICENSE NUMBER D 25861 | | 29d. DATE SIGNED (Month, Day, Year) 7-18-95 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Bruce N. McCurdy MD 724 Maiden Choice Lane Balto MD 21228 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JUL 19 1995 | | | | 32. REGISTRAR'S SIGNATURE John H. ... | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

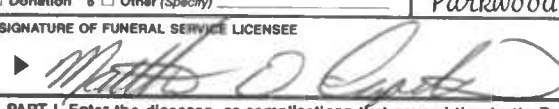


IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 21728

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|--|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) NANCY VIRGINIA SIMPKINS | | | | 2. DATE OF DEATH MONTH July DAY 14 , YEAR 1995 | | 3. TIME OF DEATH 12:10 A. M. | |
| 4. SOCIAL SECURITY NUMBER 220-24-4740 A | | 5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 8. AGE (In yrs. last birthday) 81 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) April 30, 1914 | |
| 9a. FACILITY NAME (If not institution, give street and number) Good Samaritan Nursing Home | | 9b. CITY, TOWN OR LOCATION OF DEATH Baltimore | | 9c. COUNTY OF DEATH N/A | | 8. BIRTHPLACE (State or Foreign Country) Maryland | |
| 10a. STATE Maryland | | | | 10b. COUNTY N/A | | 10c. CITY, TOWN OR LOCATION Baltimore | |
| 10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | 10e. STREET AND NUMBER 2838 Clifton Park Terrace | | 10f. ZIP CODE 21213 | |
| 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | | | | 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | |
| 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | | | 14. RACE — American Indian, Black, White, etc. Specify: White | | 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12th Grade College (1-4 or 5+) College | |
| 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Cafe Manager | | | | 16b. KIND OF BUSINESS/INDUSTRY Restaurant | | 17. FATHER'S NAME (First, Middle, Last) Norman Stack | |
| 18. MOTHER'S NAME (First, Middle, Maiden Surname) Marie Harding | | | | 19a. INFORMANT'S NAME (Type/Print) Mr. Norman Simpkins (son) | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 25 Westminster Bridge Way, Lutherville, Md 21093 | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Parkwood Cemetery | | 20c. LOCATION — City or Town, State 7/15 Baltimore, Maryland | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE  | | | | 22. NAME AND ADDRESS OF FACILITY Schimunek Funeral Homes, Inc. 3331 Brehms Lane, Baltimore, MD 21213 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → MYOCARDIAL INFARCTION DUE TO (OR AS A CONSEQUENCE OF): Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER  | | | | 29c. LICENSE NUMBER 1009267 | | 29d. DATE SIGNED (Month, Day, Year) 7-74-95 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 28440 BELAIR RD BALTO MD 21213 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JUL 19 1995 | | 32. REGISTRAR'S SIGNATURE  | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

68760

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.



TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 21729

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) Lillian Seitz | | | | 2. DATE OF DEATH MONTH July DAY 14 YEAR 1995 | | 3. TIME OF DEATH 8:20 AM | |
| 4. SOCIAL SECURITY NUMBER 217-16-7276 | | 5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 89 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) July 10, 1906 | |
| 9a. FACILITY NAME (If not institution, give street and number) 703 Myrth Avenue | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Essex | | 9c. COUNTY OF DEATH Baltimore | |
| RESIDENCE OF DECEDENT | | | | | | | |
| 10a. STATE Maryland | | 10b. COUNTY Baltimore | | 10c. CITY, TOWN OR LOCATION Essex | | 10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 10e. STREET AND NUMBER 703 Myrth Avenue | | | | 10f. ZIP CODE 21221 | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (1-4 or 5+) _____ | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Housewife | | 16b. KIND OF BUSINESS/INDUSTRY Own Home | | | |
| 17. FATHER'S NAME (First, Middle, Last) John Thon | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Margaret Hagen | | | |
| 19a. INFORMANT'S NAME (Type/Print) David Seitz | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 703 Myrth Ave. Essex, Maryland 21221 | | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) _____ | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Oak Lawn Cemetery 7/17/1995 | | DATE 7/17/1995 | | 20c. LOCATION — City or Town, State Baltimore, MD. | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE  | | | | 22. NAME AND ADDRESS OF FACILITY Bruzdinski Funeral Home P.A. 21221 1407 Eastern Ave Baltimore Maryland | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Probable lung Cancer. DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. _____ DUE TO (OR AS A CONSEQUENCE OF): c. _____ DUE TO (OR AS A CONSEQUENCE OF): d. _____ | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. _____ _____ _____ | | | | | | 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/> | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) _____ | | | | | |
| 27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) _____ _____ _____ | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO | |
| 28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) _____ _____ _____ | | | | 28d. DESCRIBE HOW INJURY OCCURRED _____ _____ _____ | | | |
| 29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. SIGNATURE AND TITLE OF CERTIFIER Dr. Shenbourne MD | | | | | |
| 29c. LICENSE NUMBER D13401 | | 29d. DATE SIGNED (Month, Day, Year) 7/14/95 | | | | | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type/Print) Dr. SHERBOURNE 4101 FRANKLIN SQ BALTO 21232 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JUL 19 1995 | | 32. REGISTRAR'S SIGNATURE  | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 21730

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) Stanley SCHALL Sr. | | | | 2. DATE OF DEATH MONTH DAY YEAR July 17, 1995 | | 3. TIME OF DEATH 6:44 P M | |
| 4. SOCIAL SECURITY NUMBER 205-03-0643 | | 5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 80 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 4-12-15 | |
| 9a. FACILITY NAME (If not institution, give street and number) Franklin Square Hospital | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Rossville | | 9c. COUNTY OF DEATH Baltimore | |
| RESIDENCE OF DECEDENT | | | | | | | |
| 10a. STATE MD | | 10b. COUNTY Baltimore | | 10c. CITY, TOWN OR LOCATION Rosedale | | 10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| 10e. STREET AND NUMBER 9136 Lennings Lane | | | | 10f. ZIP CODE 21237 | | 10g. CITIZEN OF WHAT COUNTRY? USA | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES WW II | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: white | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (9-12) 9 College (1-4 or 5+) 0 | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Parts Processor | | 16b. KIND OF BUSINESS/INDUSTRY General Motors | |
| 17. FATHER'S NAME (First, Middle, Last) John Szal | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Mary Gurdak | | | |
| 19a. INFORMANT'S NAME (Type/Print) Joan Schall | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9136 Lennings Lane, Baltimore, MD 21237 | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Gardens of Faith 7-21-95 | | 20c. LOCATION — City or Town, State Baltimore, MD | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>J. Dennis S. Kelly</i> | | | | 22. NAME AND ADDRESS OF FACILITY Cvach/Rosedale Funeral Home 1211 Chesaco Ave. | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | | a. ACUTE MYOCARDIAL INFARCTION DUE TO (OR AS A CONSEQUENCE OF): | | | | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | b. DUE TO (OR AS A CONSEQUENCE OF): | | | | | |
| | | c. DUE TO (OR AS A CONSEQUENCE OF): | | | | | |
| | | d. DUE TO (OR AS A CONSEQUENCE OF): | | | | | |
| | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | |
| DIABETES MELLITUS | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| CEREBROVASCULAR ACCIDENT | | | | | | | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| | | 28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28e. DESCRIBE HOW INJURY OCCURRED | | | |
| | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER <i>J. J. Loh</i> D.O. | | | | 29c. LICENSE NUMBER H35593 | | 29d. DATE SIGNED (Month, Day, Year) JULY 19, 1995 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) DR. JOHN J. LOH 1124 MACE AVE., BALTIMORE, MARYLAND 21221 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JUL 19 1995 | | 32. REGISTRAR'S SIGNATURE <i>John Andrew Radell</i> | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95-4178-510

blh


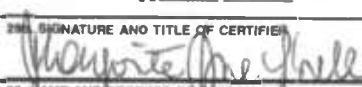
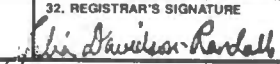
Item 16a 7-19-95 Film G725 W.H.Per F/H

95 21731

ITEMS: 23 PART I, 27, PER MEO FILM G-726 8/10/95 t.t

FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|--|--|--|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) James Dennis Stansbury, Sr. | | | | 2. DATE OF DEATH MONTH DAY YEAR July 18 1995 | | 3. TIME OF DEATH 0448 | |
| 4. SOCIAL SECURITY NUMBER 212-58-7192 | | 5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 43 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) Oct 16, 1951 | |
| 8. BIRTHPLACE (State or Foreign Country) Maryland | | | | 9a. FACILITY NAME (If not institution, give street and number) 2532 Washington Blvd. 21230 | | 9b. CITY, TOWN OR LOCATION OF DEATH Baltimore | |
| 10a. STATE Maryland | | | | 10b. COUNTY NA | | 10c. CITY, TOWN OR LOCATION Baltimore (Morrell Park) | |
| 10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | 10e. STREET AND NUMBER 2532 Washington Blvd., | | 10f. ZIP CODE 21230 | |
| 10g. CITIZEN OF WHAT COUNTRY? USA | | | | 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | |
| 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | | | 14. RACE — American Indian, Black, White, etc. Specify: White | | 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (14 or 5+) Improvements | |
| 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Home Improvements | | | | 16b. KIND OF BUSINESS/INDUSTRY Thompson Remodelling Co. | | | |
| 17. FATHER'S NAME (First, Middle, Last) Charles Michael Stansbury, Jr. | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Annette Evelyn Hale | | | |
| 19a. INFORMANT'S NAME (Type/Print) Mrs. Roberta Lee Stansbury | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2532 Washington Blvd., Baltimore, Md. 21230 | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Cedar Hill Cemetery July 21, 1995 Baltimore, Maryland | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE  Kevin E. Ecker | | | | 22. NAME AND ADDRESS OF FACILITY McCully Funeral Home of Brooklyn 237 E. Patapsco Ave., Balto., Md. 21225 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → ATHEROSCLEROTIC CARDIOVASCULAR DISEASE DUE TO (OR AS A CONSEQUENCE OF): Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide 3 <input type="checkbox"/> Homicide 8 <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | 29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER  O.C.M.E. | | | | 29c. LICENSE NUMBER O.C.M.E. | | 29d. DATE SIGNED (Month, Day, Year) July 18 1995 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) MARYLAND A. W. 111 Penn Street, Baltimore, Maryland 21201 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JUL 19 1995 | | | | 32. REGISTRAR'S SIGNATURE  | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

2000

1 -
FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) CHARLES FRANCIS SCHMITT Sr. | | | | 2. DATE OF DEATH MONTH 7 DAY 17 YEAR 95 | | 3. TIME OF DEATH 12:00 p.m. | |
| 4. SOCIAL SECURITY NUMBER 215-14-9380 | | 5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 71 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) Aug. 21, 1923 | |
| 9a. FACILITY NAME (If not institution, give street and number) Mercy Hospital/Stella Maris Hospice | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Baltimore | | 9c. COUNTY OF DEATH N/A | |
| RESIDENCE OF DECEDENT | | | | | | | |
| 10a. STATE Maryland | | 10b. COUNTY N/A | | 10c. CITY, TOWN OR LOCATION Baltimore | | 10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | |
| 10e. STREET AND NUMBER 107 N. Ellwood Avenue | | | | 10f. ZIP CODE 21224 | | 10g. CITIZEN OF WHAT COUNTRY? U. S. A. | |
| 11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES WWII | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (9-12) 10th Grade | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Chief Clerk | | 16b. KIND OF BUSINESS/INDUSTRY Shipping Broker | |
| 17. FATHER'S NAME (First, Middle, Last) Andrew J. Schmitt | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Dorothy Marx | | | |
| 19a. INFORMANT'S NAME (Type/Print) Carolyn C. Schmitt (Wife) | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 107 N. Ellwood Ave., Baltimore, Md. 21224 | | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Loudon Park Cemetery 7/17/95 | | 20c. LOCATION — City or Town, State Baltimore, Maryland | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | | | | 22. NAME AND ADDRESS OF FACILITY Schimunek Funeral Home 3331 Brehms Lane, Baltimore, Md. 21213 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | | a. Dehydration DUE TO (OR AS A CONSEQUENCE OF): b. Left Coronary Arteriosclerotic Aneurysm DUE TO (OR AS A CONSEQUENCE OF): c. Myocardial Infarction DUE TO (OR AS A CONSEQUENCE OF): d. Metastatic Colon Cancer | | | | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST | | Approximate Interval Between Onset and Death days 2 weeks ~1 year | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. @ LE DVT | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 28. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) HOSPICE | | | | | |
| 27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| | | 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, term, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER Dr. Fernando J. Ferro MD | | | | 29c. LICENSE NUMBER D40480 | | 29d. DATE SIGNED (Month, Day, Year) 7/14/95 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) FERNANDO J. FERRO MD 5810 Belair Rd Baltimore, MD 21206 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JUL 19 1995 | | | | 32. REGISTRAR'S SIGNATURE | | | |

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 5 may be retained by the attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be retained by the funeral director.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

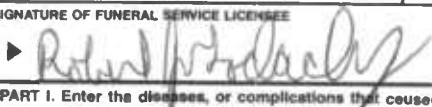

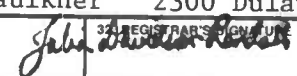
TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

95 21733

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|--|--|---|--|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last) TERRY NICHOLAS TIELL SR. | | | | 2. DATE OF DEATH MONTH DAY YEAR JULY 14, 1995 | | 3. TIME OF DEATH 9:00 A. M. | |
| 4. SOCIAL SECURITY NUMBER 213-38-8501 | | 5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 52 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) Jan. 5, 1943 | |
| 9a. FACILITY NAME (If not institution, give street and number) Stella Maris Hospice | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Baltimore | | 9c. COUNTY OF DEATH Baltimore | |
| 10a. STATE Maryland | | 10b. COUNTY Baltimore | | 10c. CITY, TOWN OR LOCATION Baltimore | | 10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 10e. STREET AND NUMBER 7912 Marfield Place, Apt. G | | | | 10f. ZIP CODE 21236 | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 2 College (1-4 or 5+) 2 | | 15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Police Officer | | 15b. KIND OF BUSINESS/INDUSTRY Baltimore City | | | |
| 17. FATHER'S NAME (First, Middle, Last) Edgar G. Tiell | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Iva Pearle Wadams | | | |
| 19a. INFORMANT'S NAME (Type/Print) Anita V. Tiell (Wife) | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7912 Marfield Place, Apt. G, Baltimore, Md. 21236 | | | |
| 20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Green Mount Crematory 7/17/95 | | 20c. LOCATION — City or Town, State Baltimore, Maryland | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE  | | | | 22. NAME AND ADDRESS OF FACILITY Schimunek Funeral Home 3331 Brehms Lane, Baltimore, Md. 21213 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → ESTHESIOBLASTOMA - SINUS CANCER DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. | | | | | | | Approximate Interval Between Onset and Death 15 yrs. |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DDA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) HOSPICE | | | | | |
| 27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| 29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER  | | | | 29c. LICENSE NUMBER D25643 | | 29d. DATE SIGNED (Month, Day, Year) 7/14/95 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Dr. Kendall Faulkner 2300 Dulaney Valley Rd. Towson, Maryland 21204 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JUL 19 1995 | | | | 32. REGISTRAR'S SIGNATURE  | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

BALTIMORE, MARYLAND 21215-0020

BALTIMORE, MARYLAND 21215-0020

12+1

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | |
|--|--|--|--|---|--|---|---|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) RICHARD J. TIETBOHL | | | | 2. DATE OF DEATH MONTH DAY YEAR JULY 13 1995 | | 3. TIME OF DEATH 8:47 A M | | | |
| 4. SOCIAL SECURITY NUMBER 165-32-5514 | | 5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 56 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) Aug. 19, 1938 | | 8. BIRTHPLACE (State or Foreign Country) Pa. | |
| 9a. FACILITY NAME (If not institution, give street and number) ST. AGNES HOSPITAL CENTER | | | | 9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE CITY | | | 9c. COUNTY OF DEATH | | |
| 10a. STATE Pa. | | 10b. COUNTY Cumberland | | 10c. CITY, TOWN OR LOCATION Camp Hill | | | 10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | |
| 10e. STREET AND NUMBER 863 Hillside Drive | | | | 10f. ZIP CODE 17011 | | 10g. CITIZEN OF WHAT COUNTRY? USA | | | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | | 14. RACE — American Indian, Black, White, etc. Specify: White | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 4 | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Teacher | | 16b. KIND OF BUSINESS/INDUSTRY Public Schools | | | | | |
| 17. FATHER'S NAME (First, Middle, Last) F. John Tietbohl | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Mary E. Miller | | | | | |
| 19a. INFORMANT'S NAME (Type/Print) Mary L. Tietbohl | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 863 Hillside Dr. Camp Hill, Pa. 17011 | | | | | |
| 20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Carroll Cremation 7-14-95 | | 20c. LOCATION — City or Town, State Hampstead, Md. | | 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | | | |
| 22. NAME AND ADDRESS OF FACILITY 11824 Reisterstown Road Eline Funeral Home Reisterstown, Md. 21136 | | | | 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Hypertensive Arteriosclerotic Cardiovascular Disease DUE TO (OR AS A CONSEQUENCE OF): a. _____ b. _____ c. _____ d. _____ Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST | | | | Approximate Interval Between Onset and Death | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED | |
| 28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| 29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER | | | | 29c. LICENSE NUMBER O.C.M.E. | | 29d. DATE SIGNED (Month, Day, Year) JULY 13, 1995 | | | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Theodore King M.D. 1111 Penn Street, Baltimore, Maryland 21201 | | | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JUL 19 1995 | | | | | | | | | |

95 21735

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) Lois V. Williams | | | | 2. DATE OF DEATH MONTH: JULY DAY: 15 YEAR: 95 | | 3. TIME OF DEATH 5:10 P.M. | |
| 4. SOCIAL SECURITY NUMBER 219-32-3632 | | 5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 68 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) April 2, 1927 | |
| 9a. FACILITY NAME (If not institution, give street and number) Northwest Hospital | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Randallstown | | 9c. COUNTY OF DEATH Balto | |
| RESIDENCE OF DECEDENT | | | | | | | |
| 10a. STATE MD | | 10b. COUNTY Balto | | 10c. CITY, TOWN OR LOCATION Randallstown | | 10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 10e. STREET AND NUMBER 3342 Ripple Road | | | | 10f. ZIP CODE 21244 | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: Black | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12): 12th grade College (1-4 or 5+): NA | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Educational Assistant | | 16b. KIND OF BUSINESS/INDUSTRY School System | |
| 17. FATHER'S NAME (First, Middle, Last) Charles Bishop | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Carrie Tyler | | | |
| 19a. INFORMANT'S NAME (Type/Print) Tyrone Williams | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3342 Ripple Road Randallstown, Md 21244 | | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Woodlawn Cemetery | | 20c. LOCATION — City or Town, State Balto, Md | | 20d. DATE 7/22/95 | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Sala March | | | | 22. NAME AND ADDRESS OF FACILITY March F. H. West 4300 Westbush Avenue Balto, Md 21215 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → HEPATO RENAL FAILURE | | | | | | | |
| Due to (or as a consequence of): PANCREATIC CANCER | | | | | | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/> | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER Dr. Pitt MD. | | | | 29c. LICENSE NUMBER D27157 | | 29d. DATE SIGNED (Month, Day, Year) JULY 15-95 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) RAYNOLD DEPESTRE NORTHWEST HOSPITAL CENTER | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JUL 19 1995 | | | | 32. REGISTRAR'S SIGNATURE John Andrew Randall | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 21736

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) TIMOTHY L. WILLIAMS JR. | | | | 2. DATE OF DEATH MONTH JULY DAY 12 YEAR 1995 | | 3. TIME OF DEATH 09:10 a.m. | |
| 4. SOCIAL SECURITY NUMBER NA | | 5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 3 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) May 21, 1992 | |
| 8. BIRTHPLACE (State or Foreign Country) md | | | | 9. FACILITY NAME (If not institution, give street and number) THE JOHNS HOPKINS HOSPITAL | | 10. CITY, TOWN OR LOCATION OF DEATH BALTIMORE CITY | |
| 11. RESIDENCE OF DECEDENT 10a. STATE md 10b. COUNTY N/A 10c. CITY, TOWN OR LOCATION Balto | | | | 12. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | 13. STREET AND NUMBER 6133 Duroming Rd | |
| 14. ZIP CODE 21239 | | | | 15. CITIZEN OF WHAT COUNTRY? U.S.A | | 16. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | |
| 17. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | | | 18. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 19. RACE — American Indian, Black, White, etc. Specify: Black | |
| 20. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) N/A College (13-16 or 5+) N/A | | | | 21. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) N/A | | 22. KIND OF BUSINESS/INDUSTRY N/A | |
| 23. FATHER'S NAME (First, Middle, Last) Timothy L. Williams | | | | 24. MOTHER'S NAME (First, Middle, Maiden Surname) Cozette King | | | |
| 25. INFORMANT'S NAME (Type, Print) Thad Martin | | | | 26. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3007 E. Biddle St. Balto, md 21212 | | | |
| 27. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 28. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Parkwood Cemetery 7/15/95 | | 29. LOCATION — City or Town, State Balto, md | |
| 30. SIGNATURE OF FUNERAL SERVICE LICENSEE Anthony E. Ward | | | | 31. NAME AND ADDRESS OF FACILITY Mank F. H. West 4300 Wabash Ave | | | |
| 32. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Acquired Immune Deficiency Syndrome b. Cardiac arrest c. d. SEQUENTIALLY LIST CONDITIONS, IF ANY, LEADING TO IMMEDIATE CAUSE. ENTER UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | | |
| 33. PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | |
| 34. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | 35. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | |
| 36. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | | | 37. DATE OF INJURY (Month, Day, Year) | | 38. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 39. PLACE OF INJURY — A1 home, farm, street, factory, office building, etc. (Specify) | | | | 40. DESCRIBE HOW INJURY OCCURRED | | | |
| 41. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | 42. CERTIFIER 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | |
| 43. SIGNATURE AND TITLE OF CERTIFIER | | | | 44. LICENSE NUMBER D26498 | | 45. DATE SIGNED (Month, Day, Year) July 12, 1995 | |
| 46. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Dr. Delores Nioku 600 n. Wolfe Street Baltimore, Md | | | | | | | |
| 47. DATE FILED (Month, Day, Year) JUL 19 1995 | | | | 48. REGISTRAR'S SIGNATURE John A. ... | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|---|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) Bernard J. Wolinski | | | | 2. DATE OF DEATH MONTH July DAY 18 YEAR 95 | | 3. TIME OF DEATH 3:17 A.M. | |
| 4. SOCIAL SECURITY NUMBER 213-10-4167 | | 5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 81 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) Sept 26 1913 | |
| 9a. FACILITY NAME (If not institution, give street and number) St. Agnes Hospital | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Baltimore | | 9c. COUNTY OF DEATH Baltimore City | |
| RESIDENCE OF DECEDENT | | | | | | | |
| 10a. STATE Maryland | | 10b. COUNTY Baltimore | | 10c. CITY, TOWN OR LOCATION Catonsville | | 10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 10e. STREET AND NUMBER 715 Maiden Choice Lane, CR410 | | | | 10f. ZIP CODE 21228 | | 10g. CITIZEN OF WHAT COUNTRY? USA | |
| 11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES 1931-1935 | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: white | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (8-12) 8 College (1-4 or 5+) _____ | | 15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Firefighter | | 15b. KIND OF BUSINESS/INDUSTRY Baltimore City Fire Dept. | | | |
| 17. FATHER'S NAME (First, Middle, Last) James WOLINSKI | | | | 16. MOTHER'S NAME (First, Middle, Maiden Surname) Lillian WOJCIECHOWSKI | | | |
| 19a. INFORMANT'S NAME (Type/Print) Bernard J. Wolinski | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9107 Ramble Brook Road, Baltimore, MD 21236 | | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) _____ | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Holy Rosary Cemetery | | DATE 7/22 | | 20c. LOCATION — City or Town, State Dundalk, MD | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>James R. Klug</i> | | | | 22. NAME AND ADDRESS OF FACILITY Hubbard Funeral Home, Inc. 4107 Wilkens Ave, Baltimore, MD 21229 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | | | | | | | |
| a. Cardiac Arrhythmia DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| b. Myocardial Infarction DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| c. Ruptured Aortic Aneurysm DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| d. _____ | | | | | | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | | | | |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO | | | | | | | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) _____ | | | | | |
| 27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M _____ | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO | |
| | | 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER <i>James R. Klug</i> | | | | 29c. LICENSE NUMBER 1884 | | 29d. DATE SIGNED (Month, Day, Year) July 19 1995 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (Item 27) (Type, Print) LIMOTHY T. KLEBER 900 CATON AVE Baltimore, MD | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JUL 19 1995 | | 32. DEATH CERTIFICATE SIGNATURE <i>John W. Randall</i> | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be attached to the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 21738

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) Raymond S. Wheeler | | | | 2. DATE OF DEATH MONTH DAY YEAR July 15, 1995 | | 3. TIME OF DEATH 5:15 P. M. | |
| 4. SOCIAL SECURITY NUMBER 216-26-7544 | | 5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 8. AGE (In yrs. last birthday) 57 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) July 12, 1938 | |
| 9a. FACILITY NAME (If not institution, give street and number) 5 McLendon Court | | 9b. CITY, TOWN OR LOCATION OF DEATH N/A | | 9c. COUNTY OF DEATH Baltimore | | | |
| 10a. STATE Maryland | | 10b. COUNTY Baltimore | | 10c. CITY, TOWN OR LOCATION N/A | | 10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| 10e. STREET AND NUMBER 5 McLendon Court | | | | 10f. ZIP CODE 21244 | | 10g. CITIZEN OF WHAT COUNTRY? USA | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 10th College (1-4 or 5+) College | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Laborer | | 16b. KIND OF BUSINESS/INDUSTRY Home Improvement/Roofing | | | |
| 17. FATHER'S NAME (First, Middle, Last) John Wheeler | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Mary Noto | | | |
| 19a. INFORMANT'S NAME (Type/Print) Debra Beidas | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8 Tentmill Lane Apt. A Baltimore, Md. 21208 | | | |
| 20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Greenmount Cemetery 7/19 | | 20c. LOCATION — City or Town, State Baltimore, Maryland | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>David J. Weber</i> | | | | 22. NAME AND ADDRESS OF FACILITY David J. Weber Funeral Home 5311 Edmondson Ave. Balto. Md. 21229 | | | |
| 23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Sudden Cardiac Death Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. Severe Ischemic Cardiomyopathy 1992 c. Severe Coronary Artery Disease Status post Coronary artery Bypass Surgery 1992 d. | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Diabetes Mellitus history of congestive heart failure Hypertensive Cardiovascular Disease DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 28. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| | | 28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28e. DESCRIBE HOW INJURY OCCURRED | | | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. SIGNATURE AND TITLE OF CERTIFIER <i>Joyce A. Zeno</i> attending physician | | 29c. LICENSE NUMBER D40925 | | 29d. DATE SIGNED (Month, Day, Year) 7/18/95 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Joyce A. Zeno, M.D. 5601 Loch Raven Blvd, Baltimore Md 21230 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JUL 19 1995 | | 32. REGISTRAR'S SIGNATURE <i>John A. ...</i> | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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95 21739

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) MARGARET WILGIS | | | | 2. DATE OF DEATH MONTH DAY YEAR July 15 1995 | | 3. TIME OF DEATH 11:35 A M | |
| 4. SOCIAL SECURITY NUMBER 212-20-4604 | | 5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 68 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) Oct. 27, 1926 | |
| 9a. FACILITY NAME (If not institution, give street and number) Church Home | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Baltimore | | 9c. COUNTY OF DEATH Baltimore City | |
| RESIDENCE OF DECEDENT | | | | | | | |
| 10a. STATE Maryland | | 10b. COUNTY Baltimore City | | 10c. CITY, TOWN OR LOCATION Baltimore | | 10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 10e. STREET AND NUMBER 515 W. 28th Street | | | | 10f. ZIP CODE 21211 | | 10g. CITIZEN OF WHAT COUNTRY? USA | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: white | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 8th College (1-4 or 5+) | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Machine Operator | | 16b. KIND OF BUSINESS/INDUSTRY Oles Envelope Company | | | |
| 17. FATHER'S NAME (First, Middle, Last) Joseph Esposito | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Dehlia | | | |
| 19a. INFORMANT'S NAME (Type/Print) Albert Hamilton, Sr. | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4 Marley Neck Rd. Glen Burnie, MD 21060 | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) West Liberty Cemetery 7/18 | | 20c. LOCATION — City or Town, State WhiteHall, Maryland | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Jacques H. Carpenter</i> | | | | 22. NAME AND ADDRESS OF FACILITY Burgee-Henss Funeral Home 3631 Falls Road Baltimore, MD 21211 | | | |
| 23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → end stage chronic obstructive lung disease > 10 yrs. Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST a. DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER <i>Dr. May Medical Specialist</i> | | | | 29c. LICENSE NUMBER 045280 | | 29d. DATE SIGNED (Month, Day, Year) 7/15/95 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) SAJJAD MALICK, 10 N. Broadway, Baltimore, MD 21231 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JUL 19 1995 | | | | 32. REGISTRAR'S SIGNATURE <i>John Anderson-Randall</i> | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 21740

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) Ella R. Walker | | | | 2. DATE OF DEATH MONTH July DAY 9 YEAR 1995 | | 3. TIME OF DEATH 9:15 A M | |
| 4. SOCIAL SECURITY NUMBER 219-18-5944 | | 5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 69 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 9/20/25 | |
| 8. BIRTHPLACE (State or Foreign Country) Maryland | | | | 9a. FACILITY NAME (If not institution, give street and number) 202 Baltimore Annapolis Blvd. | | 9b. CITY, TOWN OR LOCATION OF DEATH Severna Park | |
| 9c. COUNTY OF DEATH Anne Arundel Co. | | | | 10a. STATE Maryland | | 10b. COUNTY Anne Arundel | |
| 10c. CITY, TOWN OR LOCATION Pasadena | | | | 10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 10e. STREET AND NUMBER 764 224th Street | |
| 10f. ZIP CODE 21122 | | | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | | 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 1 | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Homemaker | | 16b. KIND OF BUSINESS/INDUSTRY Home | |
| 17. FATHER'S NAME (First, Middle, Last) Frank Brady | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Mary Ella Zimmerman | | | |
| 19a. INFORMANT'S NAME (Type/Print) Mrs. Michele O'Brien | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 202 Balto. Annp. Blvd. Severna Park, Md. 21146 | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Holy Cross Cemetery 7/12/95 | | 20c. LOCATION — City or Town, State Brooklyn Park, Md. | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Thomas J. Zimmerman</i> | | | | 22. NAME AND ADDRESS OF FACILITY McCully Funeral Home of Pasadena 3204 Mountain Road, Pasadena, Md. 21122 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Renal Failure | | | | | | | |
| b. Hypertension | | | | | | | |
| c. Hyperkalemia | | | | | | | |
| d. | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Congestive heart failure | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | | | | |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | | | | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | |
| 27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | |
| 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER <i>Stephen Zemel</i> | | | | 29c. LICENSE NUMBER D21225 | | 29d. DATE SIGNED (Month, Day, Year) 7/11/95 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Stephen Zemel M.D. 795 Asylum Rd #203 GRN BURNIE MD 21061 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JUL 19 1995 | | | | 32. REGISTRAR'S SIGNATURE <i>John P. ...</i> | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 21741

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|---|--|--|---|
| 1. DECEDENT'S NAME (First, Middle, Last) CHARLES L. YOUNKER, JR. | | | | 2. DATE OF DEATH MONTH July DAY 17 YEAR 1995 | | 3. TIME OF DEATH 4:15 AM | |
| 4. SOCIAL SECURITY NUMBER 217-24-7036 | | 5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 65 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) MAY 15 1930 | |
| 8. BIRTHPLACE (State or Foreign Country) MARYLAND | | | | 9a. FACILITY NAME (If not institution, give street and number) ESKINDALE HOSPITAL | | 9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE | |
| 9c. COUNTY OF DEATH BALTIMORE | | | | 10a. STATE MARYLAND | | 10b. COUNTY BALTIMORE | |
| 10c. CITY, TOWN OR LOCATION BALTIMORE | | | | 10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 10e. STREET AND NUMBER 1237 Linksides Drive | |
| 10f. ZIP CODE 21234 | | | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | | 11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: WHITE | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 10 YRS. College (1-4 or 5+) College | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Production Mechanic | | 16b. KIND OF BUSINESS/INDUSTRY AMERICAN NATIONAL CAN CO. | |
| 17. FATHER'S NAME (First, Middle, Last) CHARLES L. YOUNKER, SR. | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) MARY WARD FLEMING | | | |
| 19a. INFORMANT'S NAME (Type/Print) HAROLD M. YOUNKER | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1237 Linksides Drive, Baltimore, Maryland 21234 | | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) GARDENS OF FAITH | | 20c. LOCATION — City or Town, State ROOSEVELT, MARYLAND | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i> | | | | 22. NAME AND ADDRESS OF FACILITY EVANS CHAPEL OF MEMORIES 8800 HARFORD ROAD — PARKVILLE | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → congestive heart failure Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST Coronary atherosclerotic disease and stage COPD | | | | | | | Approximate Interval Between Onset and Death |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | | | | DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/> |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28e. DESCRIBE HOW INJURY OCCURRED | | | | | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | 29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i> Physician | | | | 29c. LICENSE NUMBER 344817 | | 29d. DATE SIGNED (Month, Day, Year) July 17/1995 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) SUNIL P. RAJANI 2434 W Belvedere Ave, Baltimore, MD | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JUL 19 1995 | | | | 32. REGISTRAR'S SIGNATURE <i>[Signature]</i> | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 21742

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|---|--|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last) MARY Ann ZAJAC | | | | 2. DATE OF DEATH MONTH 7 DAY 15 YEAR 95 | | 3. TIME OF DEATH 1:55 A M | |
| 4. SOCIAL SECURITY NUMBER 216-16-3339 | | 5. SEX 1 M 2 F | | 6. AGE (In yrs. last birthday) 70 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 9-8-24 | |
| 8. BIRTHPLACE (State or Foreign Country) MARYLAND | | | | 9a. FACILITY NAME (If not institution, give street and number) LORIE FRANKFORD NURSING HOME | | 9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE | |
| 9c. COUNTY OF DEATH N/A | | | | 10a. STATE MARYLAND | | | |
| 10b. COUNTY N/A | | | | 10c. CITY, TOWN OR LOCATION BALTIMORE | | | |
| 10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | | | 10e. STREET AND NUMBER 619 S. KENWOOD AVENUE | | | |
| 10f. ZIP CODE 21224 | | | | 10g. CITIZEN OF WHAT COUNTRY? USA | | | |
| 11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: WHITE | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 10 YEARS College (1-4 or 5+) N/A | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) HOMEMAKER | | 16b. KIND OF BUSINESS/INDUSTRY OWN HOME | | | |
| 17. FATHER'S NAME (First, Middle, Last) MAXIMILLAN DEMSKI | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) MARY GLINKA | | | |
| 19a. INFORMANT'S NAME (Type/Print) MRS. PHYLLIS CROCKETT | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 629 SANDY RIDGE DR. FERDALE, MARYLAND 21061 | | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) HOLY ROSARY CEMETERY 7-18 | | 20c. LOCATION — City or Town, State BALTO. CO. MD. | | 20d. DATE 7-18 | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Charles R. Kaczorowski</i> | | | | 22. NAME AND ADDRESS OF FACILITY KACZOROWSKI FUNERAL HOME 1201 DUNDALK AVENUE BALTO. MD. 21222 | | | |
| 23. PART I. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Myocardial Infarction DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. | | | | | | | Approximate interval Between Onset and Death |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Diabetes, Hypertension | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | | | | DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/> |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER <i>Lee Tannenbaum M.D.</i> | | | | 29c. LICENSE NUMBER D39763 | | 29d. DATE SIGNED (Month, Day, Year) 7/15/95 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Lee Tannenbaum, M.D. 21 Crossroads Drive, Suite #330 Owings Mills, MD | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JUL 19 1995 | | | | 32. REGISTRAR'S SIGNATURE <i>John Davidson</i> | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 21743

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|---|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) Barbara Anderson | | | | 2. DATE OF DEATH MONTH DAY YEAR June 28, 1995 | | 3. TIME OF DEATH 5:55 A.M. | |
| 4. SOCIAL SECURITY NUMBER 146-34-4712 | | 5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 51 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) April 7, 1944 | |
| 8. BIRTHPLACE (State or Foreign Country) New Jersey | | 9a. FACILITY NAME (If not institution, give street and number) 14924 Perrywood Drive | | 9b. CITY, TOWN OR LOCATION OF DEATH Burtonsville | | 9c. COUNTY OF DEATH Montgomery | |
| 10a. STATE Maryland | | 10b. COUNTY Montgomery | | 10c. CITY, TOWN OR LOCATION Burtonsville | | 10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 10e. STREET AND NUMBER 14924 Perrywood Drive | | | | 10f. ZIP CODE 20866 | | 10g. CITIZEN OF WHAT COUNTRY? United States | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 8+) 4 | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Nutritionist | | 16b. KIND OF BUSINESS/INDUSTRY Federal Gov't-USA | | | |
| 17. FATHER'S NAME (First, Middle, Last) William Bickauskas | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Theresa Steanchunas | | | |
| 19a. INFORMANT'S NAME (Type/Print) Erwin W. Anderson | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 14924 Perrywood Drive, Burtonsville, Maryland 20866 | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Parklawn Memorial Park 7/3 | | 20c. LOCATION — City or Town, State Rockville, Maryland | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Julius Davidson</i> | | | | 22. NAME AND ADDRESS OF FACILITY Hines-Rinaldi Funeral Home 11800 New Hampshire Avenue Silver Spring, Maryland 20904 | | | |
| 23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. METASTATIC NONSMALL CELL LUNG CANCER Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER <i>Carolyn B. Hendricks MD</i> | | | | 29c. LICENSE NUMBER D37236 | | 29d. DATE SIGNED (Month, Day, Year) JUNE 30, 1995 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Carolyn B. Hendricks 9707 Medical Center Dr, Suite 300, Rockville, MD 20850 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JUL 07 1995 | | 32. REGISTRAR'S SIGNATURE <i>Julius Davidson</i> | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 21744

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) Leonid Alper | | | | 2. DATE OF DEATH MONTH July DAY 02 YEAR 1995 | | 3. TIME OF DEATH 0100 P M | |
| 4. SOCIAL SECURITY NUMBER 215-25-7031 | | 5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 68 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) July 28 1926 | |
| 9a. FACILITY NAME (If not institution, give street and number) Shady Grove Hospital | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Rockville | | 9c. COUNTY OF DEATH Montgomery | |
| 10a. STATE MD | | | | 10b. COUNTY Montgomery | | 10c. CITY, TOWN OR LOCATION Gaithersburg | |
| 10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | | | 10e. STREET AND NUMBER 17060 King James Way | | | |
| 10f. ZIP CODE 20877 | | | | 10g. CITIZEN OF WHAT COUNTRY? USA | | | |
| 11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: white | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4 or 5+) <input checked="" type="checkbox"/> 4 | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Mechanical Engineer | | 16b. KIND OF BUSINESS/INDUSTRY Government | | | |
| 17. FATHER'S NAME (First, Middle, Last) Mousey Alper | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Shendel Royzen | | | |
| 19a. INFORMANT'S NAME (Type/Print) Alan A. Fisher | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 Rock Falls Court Rockville MD 20854 | | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Judean Memorial Gardens 7/3 | | 20c. LOCATION — City or Town, State Olney MD | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | | | | 22. NAME AND ADDRESS OF FACILITY Edward Sagel Funeral Direction 1091 Rockville Pike Rockville MD 20852 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → BRAIN METASTASES Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. LUNG CANCER b. c. d. Approximate interval Between Onset and Death 6 months 6 months | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/> | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | 29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. SIGNATURE AND TITLE OF CERTIFIER Philip Owen | | 29c. LICENSE NUMBER D 35635 | | 29d. DATE SIGNED (Month, Day, Year) July 2, 1995 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 18111 Prince Philip Drive, Owens, MD 20832 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JUL 05 1995 | | 32. REGISTRAR'S SIGNATURE | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 21745

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) Shafika Abunassar | | | | 2. DATE OF DEATH MONTH DAY YEAR June 30, 1995 | | 3. TIME OF DEATH 1:45 P M | |
| 4. SOCIAL SECURITY NUMBER 219-90-6352 | | 5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 86 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) Jan. 3, 1909 | |
| 8. BIRTHPLACE (State or Foreign Country) Israel | | | | 9a. FACILITY NAME (If not institution, give street and number) Washington Adventist Hospital | | 9b. CITY, TOWN OR LOCATION OF DEATH Takoma Park | |
| 9c. COUNTY OF DEATH Montgomery | | | | 10a. STATE Maryland | | 10b. COUNTY Prince Georges | |
| 10c. CITY, TOWN OR LOCATION Adelphi | | | | 10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 10e. STREET AND NUMBER 1924 Red Oak Drive | |
| 10f. ZIP CODE 20783 | | | | 10g. CITIZEN OF WHAT COUNTRY? Israel | | 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | | |
| 14. RACE — American Indian, Black, White, etc. Specify: White | | | | 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 9 College (1-4 or 5+) College (1-4 or 5+) | | | |
| 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Homemaker | | | | 16b. KIND OF BUSINESS/INDUSTRY Own Home | | | |
| 17. FATHER'S NAME (First, Middle, Last) Antone Abunassar | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Unknown Abunassar | | | |
| 19a. INFORMANT'S NAME (Type/Print) Anthony Abunassar | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8220 Spring Branch Court Laurel, Maryland 20823 | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) George Washington Cemetery 7/2/95 DATE | | | |
| 20c. LOCATION — City or Town, State Adelphi, Maryland | | | | 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | | | |
| 22. NAME AND ADDRESS OF FACILITY Francis J. Collins Funeral Home, Inc. 500 University Blvd., W. Sil. Spr., MD 20901 | | | | 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Congestive heart failure DUE TO (OR AS A CONSEQUENCE OF): b. Myocardial infarction DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Renal failure | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide | | | | 28a. DATE OF INJURY (Month, Day, Year) June 30, 1995 | | | |
| 28b. TIME OF INJURY M | | | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER | | | | 29c. LICENSE NUMBER D34601 | | | |
| 29d. DATE SIGNED (Month, Day, Year) JUNE 30, 1995 | | | | 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) DAVID M. BRILL MD 7600 Carroll Ave Takoma Park MD 20912 | | | |
| 31. DATE FILED (Month, Day, Year) JUL 03 1995 | | | | 32. REGISTRAR'S SIGNATURE | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.



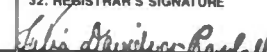
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR
STATE
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | | | | | |
|---|--|--|--|--|--|--|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) Doris Redford Ammon | | | | 2. DATE OF DEATH MONTH DAY YEAR June 30, 1995 | | | | 3. TIME OF DEATH 5:45 A. | | | | | |
| 4. SOCIAL SECURITY NUMBER 201-05-4630 | | 5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 84 YRS. | | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS. HOURS MIN. | | 7. DATE OF BIRTH (Month, Day, Year) March 11, 1911 | | 8. BIRTHPLACE (State or Foreign Country) Pennsylvania | |
| 9a. FACILITY NAME (If not Institution, give street and number) 5 Melmark Court | | | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Gaithersburg | | | | | | 9c. COUNTY OF DEATH Montgomery | |
| 10a. STATE Maryland | | 10b. COUNTY Montgomery | | 10c. CITY, TOWN OR LOCATION Gaithersburg | | | | | | 10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | |
| 10e. STREET AND NUMBER 5 Melmark Court | | | | | | 10f. ZIP CODE 20878 | | | | 10g. CITIZEN OF WHAT COUNTRY? United States | | | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | | | 14. RACE — American Indian, Black, White, etc. Specify: White | | | | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Operator | | | | 16b. KIND OF BUSINESS/INDUSTRY Telephone Company | | | | | | | |
| 17. FATHER'S NAME (First, Middle, Last) Reginald Redford | | | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Muriel Morris | | | | | | | |
| 19a. INFORMANT'S NAME (Type/Print) Gail D. Williams | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5 Melmark Court, Gaithersburg, Maryland 20878 | | | | | | | | | |
| 20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Metropolitan Crematory 7/1 | | | | 20c. LOCATION — City or Town, State Alexandria, Virginia | | | | | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE  | | | | 22. NAME AND ADDRESS OF FACILITY DeVol Funeral Home 10 E. Deer Park Dr., Gaithersburg, MD. 20877 | | | | | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → e. Cerebrovascular Accident DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. Atherosclerosis DUE TO (OR AS A CONSEQUENCE OF): c. Senile Dementia, Coronary Insufficiency DUE TO (OR AS A CONSEQUENCE OF): d. | | | | | | | | | | Approximate Interval Between Onset and Death minutes 10 Years | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Senile Dementia, Coronary Insufficiency | | | | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? released 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO Mayle | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | | | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 6 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED | | | | | |
| 28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER  | | | | | | 29c. LICENSE NUMBER D 13977 | | 29d. DATE SIGNED (Month, Day, Year) June 30, 1995 | | | | | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Robert Millman, M.D., 9707 Medical Center Drive, #150, Rockville, MD. 20850-3360 | | | | | | | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JUL 06 1995 | | 32. REGISTRAR'S SIGNATURE  | | | | | | | | | | | |

95 21747

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) Lempi Houtari Allan | | | | 2. DATE OF DEATH MONTH DAY YEAR July 10, 1995 | | 3. TIME OF DEATH 7:30 A M | |
| 4. SOCIAL SECURITY NUMBER 129-38-2759 | | 5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 84 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) March 6, 1911 | |
| 8. BIRTHPLACE (State or Foreign Country) Minnesota | | | | 9a. FACILITY NAME (If not institution, give street and number) Physicians Memorial Hospital | | 9b. CITY, TOWN OR LOCATION OF DEATH La Plata | |
| 9c. COUNTY OF DEATH Charles | | | | 10a. STATE Maryland | | 10b. COUNTY Charles | |
| 10c. CITY, TOWN OR LOCATION Bryans Road | | | | 10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 10e. STREET AND NUMBER 5970 River Road | |
| 10f. ZIP CODE 20616 | | | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | | 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 3 | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) School Teacher | | 16b. KIND OF BUSINESS/INDUSTRY Teaching | |
| 17. FATHER'S NAME (First, Middle, Last) Juuso Houtari | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Leena Kaisa Houtari | | | |
| 19a. INFORMANT'S NAME (Type/Print) Margaret A. Boyle | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5970 River Road Bryans Road, MD 20616 | | | |
| 20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Metropolitan Crematory 7/10 | | 20c. LOCATION — City or Town, State Alexandria, VA | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE M00817 Morton C. Echols III | | | | 22. NAME AND ADDRESS OF FACILITY Arehart-Echols Funeral Home, Inc. P.O. Box 567 La Plata, MD 20646 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Sudden Cardiac Death DUE TO (OR AS A CONSEQUENCE OF): Probable Cardiac Arrhythmia DUE TO (OR AS A CONSEQUENCE OF): Coronary artery Disease DUE TO (OR AS A CONSEQUENCE OF): Chronic Renal Failure Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | | Approximate Interval Between Onset and Death |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Chronic Rheumatoid Arthritis Anemia, Bacterial Pneumonia | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | | | | DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/> |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER Sanjeeb Mishra | | | | 29c. LICENSE NUMBER D-23021 | | 29d. DATE SIGNED (Month, Day, Year) 7/10/95 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Sanjeeb Mishra, M.D. 7C Post Office Road, Cenna Center Waldorf, Maryland 20602 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JUL 11 1995 | | | | 32. REGISTRAR'S SIGNATURE Julia A. Walker-Randall | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 21748

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|---|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) <u>Pearl Alston</u> | | | | 2. DATE OF DEATH MONTH <u>07</u> DAY <u>03</u> YEAR <u>95</u> | | 3. TIME OF DEATH <u>10:44 A.M.</u> | |
| 4. SOCIAL SECURITY NUMBER <u>246-24-6048</u> | | 5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) <u>71</u> YRS. | | 7. DATE OF BIRTH (Month, Day, Year) <u>NOV. 18, 1923</u> | |
| 8. FACILITY NAME (If not institution, give street and number) <u>HARFORD MEMORIAL HOSPITAL</u> | | | | 9. CITY, TOWN OR LOCATION OF DEATH <u>HARFORD DE GRACE</u> | | 10. COUNTY OF DEATH <u>HARFORD</u> | |
| 10a. STATE <u>MD</u> | | 10b. COUNTY <u>HARFORD</u> | | 10c. CITY, TOWN OR LOCATION <u>HARFORD DE GRACE</u> | | 10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | |
| 10e. STREET AND NUMBER <u>119 GEORGE CT.</u> | | | | 10f. ZIP CODE <u>21078</u> | | 10g. CITIZEN OF WHAT COUNTRY? <u>USA</u> | |
| 11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: <u>BLACK</u> | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4 or 5+) <input type="checkbox"/> | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <u>HOME MAKER</u> | | 16b. KIND OF BUSINESS/INDUSTRY | | | |
| 17. FATHER'S NAME (First, Middle, Last) <u>OREN ALSTON</u> | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) <u>MATTIE STRUT</u> | | | |
| 19a. INFORMANT'S NAME (Type/Print) <u>CARLIE THOMAS</u> | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>119 GEORGE CT. HARFORD DE GRACE, MD 21078</u> | | | |
| 20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input checked="" type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematorium or other place) <u>BERKELEY CEMETERY</u> | | 20c. LOCATION — City or Town, State <u>7/6 DARLINGTON, MD</u> | | 20d. DATE <u>7/6</u> | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <u>[Signature]</u> | | | | 22. NAME AND ADDRESS OF FACILITY <u>BEARD FUNERAL HOME HARFORD DE GRACE, MD 21078</u> | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | | <u>a. Ventricular fibrillation</u> DUE TO (OR AS A CONSEQUENCE OF): <u>b. Dilated cardiomyopathy</u> DUE TO (OR AS A CONSEQUENCE OF): <u>c. Hypertensive or accelerated cardiovascular disease</u> DUE TO (OR AS A CONSEQUENCE OF): <u>d. [blank]</u> | | | | | |
| Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | <u>few years in any</u> <u>years</u> | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>Chronic obstructive pulmonary disease</u> <u>Nephrotic Syndrome, S/P permanent placement</u> | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY <u>M</u> | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 28d. DESCRIBE NOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER <u>[Signature]</u> <u>SAINT W. KIM, M.D.</u> | | | | 29c. LICENSE NUMBER <u>015103</u> | | 29d. DATE SIGNED (Month, Day, Year) <u>7/3/95</u> | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <u>SAINT W. KIM, M.D.</u> | | | | | | | |
| 31. DATE FILED (Month, Day, Year) <u>JUL 11 1995</u> | | | | 32. REGISTRAR'S SIGNATURE <u>[Signature]</u> | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL DR. ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95-3875-035

blh

95 21749

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|---|--|--|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) Robert Christopher Adams | | | | 2. DATE OF DEATH MONTH DAY YEAR July 05 1995 | | 3. TIME OF DEATH 0010 M | |
| 4. SOCIAL SECURITY NUMBER 214-11-7726 | | 5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 23 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) March 3, 1972 | |
| 8. BIRTHPLACE (State or Foreign Country) Maryland | | | | 9. FACILITY NAME (If not institution, give street and number) 2526 Roberts Station Road | | 10. CITY, TOWN OR LOCATION OF DEATH Ingleaside | |
| 11. RESIDENCE OF DECEDENT 10a. STATE: Maryland 10b. COUNTY: Queen Annes 10c. CITY, TOWN OR LOCATION: Chestertown | | | | 12. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 13. CITIZEN OF WHAT COUNTRY? United States | |
| 14. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | | | 15. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 16. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | |
| 17. DECEDECENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (9-12) 12 College (1-4 or 5 +) | | | | 18. DECEDECENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Lawn Care | | 19. KIND OF BUSINESS/INDUSTRY Landscape | |
| 20. FATHER'S NAME (First, Middle, Last) Robert L. Adams | | | | 21. MOTHER'S NAME (First, Middle, Maiden Surname) Linda Barger | | | |
| 22. INFORMANT'S NAME (Type/Print) Robert L. Adams | | | | 23. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8326 Broad Neck Road, Chestertown, Maryland 21620 | | | |
| 24. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 25. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) St. Pauls Cemetery - July 9, 1995 | | 26. LOCATION — City or Town, State Chestertown, Maryland | |
| 27. SIGNATURE OF FUNERAL SERVICE LICENSEE William L. King Jr | | | | 28. NAME AND ADDRESS OF FACILITY Fellows - Wells Funeral Home 413 West High Street - Chestertown, Maryland 21620 | | | |
| 29. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Contact gunshot wound of head Due to (OR AS A CONSEQUENCE OF): b. Due to (OR AS A CONSEQUENCE OF): c. Due to (OR AS A CONSEQUENCE OF): d. Due to (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | |
| 29a. WAS AN AUTOPSY PERFORMED? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | 29b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | |
| 30. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 31. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) at scene | | | | | |
| 32. MANNER OF DEATH 1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input checked="" type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | 33. DATE OF INJURY (Month, Day, Year) 7-5-95 | | 34. TIME OF INJURY 0003 M | | 35. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| 36. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) STREET | | 37. DESCRIBE HOW INJURY OCCURRED SUBJECT SHOT SELF | | | | | |
| 38. LOCATION (Street and Number or Rural Route Number, City or Town, State) 2526 Roberts Station Road | | 39. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | |
| 40. SIGNATURE AND TITLE OF CERTIFIER [Signature] | | | | 41. LICENSE NUMBER O.C.M.E. | | 42. DATE SIGNED (Month, Day, Year) July 05 1995 | |
| 43. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 111 Penn Street, Baltimore, Maryland 21201 | | | | | | | |
| 44. DATE FILED (Month, Day, Year) JUL 06 '95 | | 45. REGISTRAR'S SIGNATURE Julia Davidson-Randall | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95-21750

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) MARGUERITE AGNES APPLEBY SR. | | | | 2. DATE OF DEATH JUNE 21, 1995 | | 3. TIME OF DEATH 2:15 A M | |
| 4. SOCIAL SECURITY NUMBER 213-48-0185 | | 5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 82 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) JUNE 7, 1913 | |
| 8. BIRTHPLACE (State or Foreign Country) WASHINGTON, D.C. | | | | 9a. FACILITY NAME (If not institution, give street and number) 24219 RIDGE ROAD | | 9b. CITY, TOWN OR LOCATION OF DEATH DAMASCUS | |
| 9c. COUNTY OF DEATH MONTGOMERY | | | | 10a. STATE MARYLAND | | 10b. COUNTY MONTGOMERY | |
| 10c. CITY, TOWN OR LOCATION DAMASCUS | | | | 10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 10e. STREET AND NUMBER 24219 RIDGE ROAD | |
| 10f. ZIP CODE 20872 | | | | 10g. CITIZEN OF WHAT COUNTRY? UNITED STATES | | 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR OATES | | | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: WHITE | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 5 | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) ARTIST - ANTIQUE DEALER | | 16b. KIND OF BUSINESS/INDUSTRY ANTIQUARY SHOP | |
| 17. FATHER'S NAME (First, Middle, Last) RAYMOND RILEY | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) FLORENCE MUNCH | | | |
| 19a. INFORMANT'S NAME (Type/Print) GEORGE W. APPLEBY | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3812 BROOKE MEADOW LANE OLNEY, MARYLAND 20832 | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE AND DATE OF DISPOSITION (Name of institution, cemetery, or other place) MONTGOMERY CEMETERY | | 20c. LOCATION — City or Town, State CLAGGETTSVILLE, MD. | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Muriel H. Barber</i> | | | | 22. NAME AND ADDRESS OF FACILITY MURIEL H. BARBER FUNERAL HOME 20882 P.O. BOX 5038 LAYTONSVILLE, MARYLAND | | | |
| 23. PART I. Enter the diseases, for complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. TERMINAL STATE 5 QUINAPRONE CALL CA ORAL 3/95 b. HYPERTENSION c. HEART FAILURE d. DEMENTIA Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | |
| 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | 28d. DESCRIBE HOW INJURY OCCURRED | | | |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER <i>Heeta Anjum, MD</i> | | | | 29c. LICENSE NUMBER D00995-MD | | 29d. DATE SIGNED (Month, Day, Year) JUNE 21, 1995 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Heeta Anjum, M.D., 18730 GERMAN TOWN, MARYLAND 20874 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JUL 18 1995 | | | | 32. REGISTRAR'S SIGNATURE <i>John M. ...</i> | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760


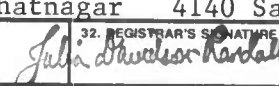
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|--|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) ROBERT E. BIRCH | | | | 2. DATE OF DEATH MONTH DAY YEAR June 29, 1995 | | 3. TIME OF DEATH 10:45 PM M | |
| 4. SOCIAL SECURITY NUMBER 213-80-5747 | | 5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 79 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) June 22, 1916 | |
| 8. BIRTHPLACE (State or Foreign Country) Virginia | | | | 9a. FACILITY NAME (If not institution, give street and number) 13718 Old Columbia Pike | | 9b. CITY, TOWN OR LOCATION OF DEATH Silver Spring | |
| 9c. COUNTY OF DEATH Montgomery | | | | 10a. STATE MD | | 10b. COUNTY Montgomery | |
| 10c. CITY, TOWN OR LOCATION Silver Spring | | | | 10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 10e. STREET AND NUMBER 13718 Old Columbia Pike | |
| 10f. ZIP CODE 20904 | | | | 10g. CITIZEN OF WHAT COUNTRY? United States | | 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES 1940-1945 | | | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: Amer. Indian | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) --- | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Superintendent | | 16b. KIND OF BUSINESS/INDUSTRY Percontee Construction | |
| 17. FATHER'S NAME (First, Middle, Last) William Edward Birch | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Ruth Margaret Payne | | | |
| 19a. INFORMANT'S NAME (Type/Print) Dorothy Alice Birch | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13718 Old Columbia Pike, Silver Spring, MD 20904 | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Union Cemetery 7/3/95 | | 20c. LOCATION — City or Town, State Burtonsville, MD | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE  | | | | 22. NAME AND ADDRESS OF FACILITY Hines-Rinaldi Funeral Home 11800 New Hampshire Ave Silver Spring MD | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Cardiac arrhythmia DUE TO (OR AS A CONSEQUENCE OF): b. ASCVD DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Approximate Interval Between Onset and Death 15 mins | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. COPD HTN DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Nomicide 8 <input type="checkbox"/> Not determined | | | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | 28d. DESCRIBE HOW INJURY OCCURRED | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | 29b. SIGNATURE AND TITLE OF CERTIFIER Sona Bhatnagar MD | | | |
| 29c. LICENSE NUMBER D44582 | | | | 29d. DATE SIGNED (Month, Day, Year) 6/30/95 | | | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Dr. Sona Bhatnagar 4140 Sandy Spring Road, Burtonsville, MD | | | | | | | |
| 31. DATE FILED (Month, Day, Year) 07 1995 | | | | 32. REGISTRAR'S SIGNATURE  | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

15+1

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 21752

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) ESTEL ANDREW BILLINGS | | | | 2. DATE OF DEATH MONTH JULY DAY 4 , YEAR 1995 | | 3. TIME OF DEATH 11:00 P M | |
| 4. SOCIAL SECURITY NUMBER 233-28-6935 | | 5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 79 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) JULY 26, 1915 | |
| 8. BIRTHPLACE (State or Foreign Country) VIRGINIA | | | | 9a. FACILITY NAME (If not institution, give street and number) 528 BRENTWOOD RD. | | 9b. CITY, TOWN OR LOCATION OF DEATH EDGEWATER | |
| 9c. COUNTY OF DEATH ANNE ARUNDEL | | | | 10a. STATE MD. | | 10b. COUNTY PRINCE GEORGES | |
| 10c. CITY, TOWN OR LOCATION RIVERDALE | | | | 10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | 10e. STREET AND NO NUMBER 4801 MADISON ST. | |
| 10f. ZIP CODE 20737 | | | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | | 11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES 1935-1937 | | | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | | |
| 14. RACE — American Indian, Black, White, etc. Specify: WHITE | | | | 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (14 or 5+) College | | | |
| 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) MECHANIC | | | | 16b. KIND OF BUSINESS/INDUSTRY AUTO | | | |
| 17. FATHER'S NAME (First, Middle, Last) CALVIN BILLINGS | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) ETHEL PAULEY | | | |
| 19a. INFORMANT'S NAME (Type/Print) LILLIAN A. BILLINGS | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) SAME AS ITEM #10 | | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) FT. LINCOLN CEMETERY 6/7 | | | |
| 20c. LOCATION — City or Town, State BRENTWOOD, MD. | | | | 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>W.W. Chambers</i> M00091 | | | |
| 22. NAME AND ADDRESS OF FACILITY W. W. CHAMBERS CO., RIVERDALE, MD. 20737 | | | | 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. bronchogenic carcinoma & metastasis nodes DUE TO (OR AS A CONSEQUENCE OF): b. chronic obstructive pulmonary disease months DUE TO (OR AS A CONSEQUENCE OF): c. coronary artery disease months DUE TO (OR AS A CONSEQUENCE OF): d. | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Cancer of the prostate | | | | 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA <input type="checkbox"/> OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | |
| 27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | | | 28a. DATE OF INJURY (Month, Day, Year) | | | |
| 28b. TIME OF INJURY M | | | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | |
| 28d. DESCRIBE HOW INJURY OCCURED | | | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | 29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER <i>Marie A. Dobyns MD</i> | | | | 29c. LICENSE NUMBER D29923 | | | |
| 29d. DATE SIGNED (Month, Day, Year) 7/5/95 | | | | 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) MARIE A. DOBYNS 7243 B Hampshire Parkway, Greenbelt MD. 20770 | | | |
| 31. DATE FILED (Month, Day, Year) JUL 07 1995 | | | | 32. REGISTRAR'S SIGNATURE <i>Julia Davidson Randall</i> | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) ANTHONY BONO | | | | 2. DATE OF DEATH MONTH JULY DAY 5 , YEAR 1995 | | 3. TIME OF DEATH 5:30 A.M. | |
| 4. SOCIAL SECURITY NUMBER 081-09-0631 | | 5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs., last birthday) 83 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) JUNE 2, 1912 | |
| 8. BIRTHPLACE (State or Foreign Country) NEW YORK | | | | 9a. FACILITY NAME (If not institution, give street and number) SHADY GROVE ADVENTIST NURSING CENTER | | 9b. CITY, TOWN OR LOCATION OF DEATH ROCKVILLE | |
| 9c. COUNTY OF DEATH MONTGOMERY | | | | 10a. STATE MD. | | 10b. COUNTY MONTGOMERY | |
| 10c. CITY, TOWN OR LOCATION GAITHERSBURG | | | | 10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | 10e. STREET AND NUMBER 800 AMBER TREE CT. | |
| 10f. ZIP CODE 20878 | | | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | | 11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | | |
| 14. RACE — American Indian, Black, White, etc. Specify: WHITE | | | | 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (14 or 5+) COSMETIC CHEMIST | | | |
| 16. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) PARA LAB. | | | | 17. FATHER'S NAME (First, Middle, Last) BARTHELOMEW BONO | | | |
| 18. MOTHER'S NAME (First, Middle, Maiden Surname) THERESA PALEAO | | | | 19a. INFORMANT'S NAME (Type/Print) THERESA M. BONO | | | |
| 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10406 NOLAN DR., ROCKVILLE, MD. 20850 | | | | 20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | |
| 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) CHAMBERS CREMATORY 7/6 | | | | 20c. LOCATION — City or Town, State RIVERDALE, MD. | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>W.W. Chambers</i> MO0091 | | | | 22. NAME AND ADDRESS OF FACILITY W. W. CHAMBERS CO. INC., SILVER SPRING, MD. 20910 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Cardiac arrest / Respiratory / Carcinoid Metastasis to Liver Approximate Interval Between Onset and Death 5-6 Years ago Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST Renal Failure Hypertension | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Chronic Renal Failure CHF. Atrial Fibrillation | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER <i>Maryam Mizrahi MD</i> | | | | 29c. LICENSE NUMBER D34505 | | 29d. DATE SIGNED (Month, Day, Year) 7-5-95 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) MARYAM. MIZRAHI MD. 902 Wind River Lane - Gaithersburg MD | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JUL 07 1995 | | | | 32. REGISTRAR'S SIGNATURE <i>John A. ...</i> | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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95 21754

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|--|--|--|--|--|---|
| 1. DECEDENT'S NAME (First, Middle, Last) James Franklin Bruner | | | | 2. DATE OF DEATH MONTH DAY YEAR 06 29 95 | | 3. TIME OF DEATH 4:30p M | |
| 4. SOCIAL SECURITY NUMBER 215-38-7076 | | 5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 54 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 09-21-40 | |
| 8. BIRTHPLACE (State or Foreign Country) MD | | | | 9a. FACILITY NAME (If not institution, give street and number) Maryland Correctional Inst. | | 9b. CITY, TOWN OR LOCATION OF DEATH Hagerstown | |
| 9c. COUNTY OF DEATH Washington | | | | 10a. STATE Maryland | | 10b. COUNTY Montgomery | |
| 10c. CITY, TOWN OR LOCATION Rockville | | | | 10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | 10e. STREET AND NUMBER 215 Ashley Ave, | |
| 10f. ZIP CODE 20850 | | | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | | 11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced | |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | | |
| 14. RACE — American Indian, Black, White, etc. Specify: Black | | | | 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 10th College (1-4 or 5+) College | | | |
| 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Laborer | | | | 16b. KIND OF BUSINESS/INDUSTRY None | | | |
| 17. FATHER'S NAME (First, Middle, Last) Brownell Brunner | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Helen Green | | | |
| 19a. INFORMANT'S NAME (Type/Print) Ethel Nicely (Daughter) | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5702 Ridgeway Ave., Rockville, MD 20851 | | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Lincoln Park Cemetery 7/7 | | 20c. LOCATION — City or Town, State Rockville, MD | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i> | | | | 22. NAME AND ADDRESS OF FACILITY SNOWDEN FUNERAL HOME, P.A. ROCKVILLE, MD 20850 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Congestive Heart Failure DUE TO (OR AS A CONSEQUENCE OF): b. Congestive Cardiomyopathy DUE TO (OR AS A CONSEQUENCE OF): c. Chronic Obstructive Pulmonary Disease DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | | Approximate Interval Between Onset and Death |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) | | | |
| 27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M <input type="checkbox"/> YES <input type="checkbox"/> NO | |
| 28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO | | | | 28d. DESCRIBE HOW INJURY OCCURRED | | | |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER Jima Telele, MD | | | | 29c. LICENSE NUMBER D-46895 | | 29d. DATE SIGNED (Month, Day, Year) 06/29/95 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) JIMA TELELE, MD - 18601 Roxbury Rd. Hagerstown, MD 21746 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JUL 05 1995 | | | | 32. REGISTRAR'S SIGNATURE <i>[Signature]</i> | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.


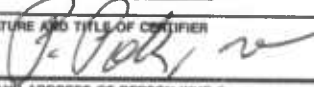
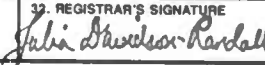
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 21755

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) Marion B. Bower | | | | 2. DATE OF DEATH MONTH DAY YEAR June 28, 1995 | | 3. TIME OF DEATH 3:10 A M | |
| 4. SOCIAL SECURITY NUMBER 213-48-0282 | | 5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 82 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) Sept. 1, 1912 | |
| 8a. FACILITY NAME (If not institution, give street and number) 15801 Norman Drive | | | | 8b. CITY, TOWN OR LOCATION OF DEATH Darnestown | | 8c. COUNTY OF DEATH Montgomery | |
| 9a. RESIDENCE OF DECEDENT 10a. STATE Maryland | | | | 10b. COUNTY Montgomery | | 10c. CITY, TOWN OR LOCATION Silver Spring | |
| 10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | 10e. STREET AND NUMBER 9305 Longbranch Parkway | | | |
| 10f. ZIP CODE 20901 | | | | 10g. CITIZEN OF WHAT COUNTRY? USA | | | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 2 | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Homemaker | | 16b. KIND OF BUSINESS/INDUSTRY Own Home | | | |
| 17. FATHER'S NAME (First, Middle, Last) James Brothwell | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Gertrude Frostberg | | | |
| 19a. INFORMANT'S NAME (Type/Print) Shelley B. Welter | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 15801 Norman Dr., Darnestown, MD 20878 | | | |
| 20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Metropolitan Crematory 7/1/95 | | 20c. LOCATION — City or Town, State Alexandria, VA | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE  | | | | 22. NAME AND ADDRESS OF FACILITY Francis J. Collins Funeral Home, Inc. 500 University Blvd. W. Sil. Spr. MD 20901 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Cardio-Respiratory Failure DUE TO (OR AS A CONSEQUENCE OF): b. Pneumonia DUE TO (OR AS A CONSEQUENCE OF): c. Lymphoma DUE TO (OR AS A CONSEQUENCE OF): d. Approximate Interval Between Onset and Death 4 min. 3 days 4 mos. | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 6 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER  | | | | 29c. LICENSE NUMBER D22309 | | 29d. DATE SIGNED (Month, Day, Year) June 30, 1995 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Phillip W. Roth, M. D. 831 University Blvd. East, #32, Silver Spring, MD 20903-2916 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JUL 03 1995 | | | | 32. REGISTRAR'S SIGNATURE  | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 21756

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) Edna May Beverly | | | | 2. DATE OF DEATH MONTH DAY YEAR June 28, 1995 | | 3. TIME OF DEATH 4:05 P M | |
| 4. SOCIAL SECURITY NUMBER 218-30-7964 | | 5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 92 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) Oct. 12, 1902 | |
| 9a. FACILITY NAME (If not institution, give street and number) Brooke Grove Nursing Home | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Olney | | 9c. COUNTY OF DEATH MONTGOMERY | |
| RESIDENCE OF DECEDENT | | | | | | | |
| 10a. STATE Maryland | | 10b. COUNTY Montgomery | | 10c. CITY, TOWN OR LOCATION Silver Spring | | 10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| 10e. STREET AND NUMBER 15526 Holly Grove Road | | | | 10f. ZIP CODE 20905 | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: Black | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 7th College (1-4 or 5+) | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Housewife | | 16b. KIND OF BUSINESS/INDUSTRY None | |
| 17. FATHER'S NAME (First, Middle, Last) Walter White | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Malinda Dublin | | | |
| 19a. INFORMANT'S NAME (Type/Print) Martha Rheubottom (Cousin) | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 18610 New Hampshire Ave., Ashton, MD 20861 | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Ash Memorial Cemetery 7/3 | | 20c. DATE 7/3 | | 20d. LOCATION — City or Town, State Sandy Spring, MD | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>George L. Snowden</i> | | | | 22. NAME AND ADDRESS OF FACILITY SNOWDEN FUNERAL HOME, P.A. ROCKVILLE, MD 20850 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Cerebrovascular accident DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Fractured Right Hip | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input checked="" type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) June 16 95 | | 28b. TIME OF INJURY unk M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED Fall | | | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) Home | | | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) 15526 Holly Grove Rd | | | | | | | |
| 29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER <i>John Tamber</i> MD | | | | 29c. LICENSE NUMBER D08746 | | 29d. DATE SIGNED (Month, Day, Year) June 29 95 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>John Tamber</i> 8218 Wisconsin Ave. MD | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JUL 03 1995 | | | | 32. REGISTRAR'S SIGNATURE <i>Julia Davidson Randall</i> | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 21757

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|---|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) Anna Rosalie Bolton | | | | 2. DATE OF DEATH MONTH DAY YEAR July 1, 1995 | | 3. TIME OF DEATH 10:40 AM | |
| 4. SOCIAL SECURITY NUMBER 578-24-1711 | | 5. SEX 1 <input type="checkbox"/> M 2 <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 69 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) Nov. 17, 1925 | |
| 8. BIRTHPLACE (State or Foreign Country) Virginia | | | | 9a. FACILITY NAME (If not institution, give street and number) Holy Cross Hospital | | 9b. CITY, TOWN OR LOCATION OF DEATH Silver Spring | |
| 9c. COUNTY OF DEATH Montgomery | | | | 10a. STATE Maryland | | 10b. COUNTY Montgomery | |
| 10c. CITY, TOWN OR LOCATION Silver Spring | | | | 10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 10e. STREET AND NUMBER 321 University Boulevard, West #212 | |
| 10f. ZIP CODE 20901 | | | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | | 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (1-4 or 5+) 8 | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Bookkeeper | | 16b. KIND OF BUSINESS/INDUSTRY Retail | |
| 17. FATHER'S NAME (First, Middle, Last) Robert Elmer Sherman | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Frances Virginia Palmer | | | |
| 19a. INFORMANT'S NAME (Type/Print) John Bolton, III | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 508 Claggett Street Leesburg, Virginia 22075 | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Fort Lincoln Cemetery 7/6/95 | | 20c. LOCATION — City or Town, State Brentwood, Maryland | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Mark S. Vetter</i> | | | | 22. NAME AND ADDRESS OF FACILITY Francis J. Collins Funeral Home, Inc. 500 University Blvd., W. Sil. Spr., MD 20901 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <u>RESPIRATORY ARREST</u> DUE TO (OR AS A CONSEQUENCE OF): b. <u>PNEUMONIA WITH LUNG ABSCESS</u> DUE TO (OR AS A CONSEQUENCE OF): c. <u>METASTATIC GASTRIC CARCINOMA</u> DUE TO (OR AS A CONSEQUENCE OF): d. Approximate interval between Onset and Death MINUTES DAYS MONTHS | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>Chronic Active Hepatitis</u> | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | | | | |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | | | | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | 28d. DESCRIBE HOW INJURY OCCURRED | | | |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | 29b. SIGNATURE AND TITLE OF CERTIFIER <i>John J. Merendino Jr MD</i> | | | |
| 29c. LICENSE NUMBER D36046 | | | | 29d. DATE SIGNED (Month, Day, Year) 7/1/95 | | | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) John J. Merendino Jr MD 4704 RANDOLPH RD #216 ROCKVILLE, MD 20852 | | | | 31. DATE FILLED (Month, Day, Year) JUL 06 1995 | | | |
| 32. REGISTRAR'S SIGNATURE <i>John Davidson Randall</i> | | | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760


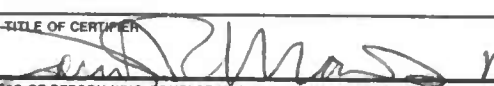
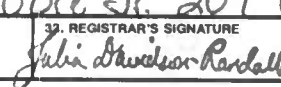
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 21758

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) Elizabeth Mae Burst | | | | 2. DATE OF DEATH MONTH DAY YEAR June 29, 1995 | | 3. TIME OF DEATH 7:50 A. M | |
| 4. SOCIAL SECURITY NUMBER 579-01-3825 | | 5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 92 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) May 14, 1903 | |
| 8. BIRTHPLACE (State or Foreign Country) Maryland | | | | 9a. FACILITY NAME (If not institution, give street and number) Wilson Health Care Center | | 9b. CITY, TOWN OR LOCATION OF DEATH Gaithersburg | |
| 9c. COUNTY OF DEATH Montgomery | | | | 10a. STATE Maryland | | 10b. COUNTY Montgomery | |
| 10c. CITY, TOWN OR LOCATION Gaithersburg | | | | 10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 10e. STREET AND NUMBER 301 Russell Avenue #316B | |
| 10f. ZIP CODE 20877 | | | | 10g. CITIZEN OF WHAT COUNTRY? United States | | 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 7 College (1-4 or 5+) | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Accounting Clerk | | 16b. KIND OF BUSINESS/INDUSTRY Department Store | |
| 17. FATHER'S NAME (First, Middle, Last) Charles A. Van Horn | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Harriet L. Easton | | | |
| 19a. INFORMANT'S NAME (Type/Print) Mary Louise Wall | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 24308 Ridge Road, Damascus, Maryland 20872 | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Rock Creek Cemetery 7/3 | | 20c. LOCATION — City or Town, State Washington, D.C. | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE  | | | | 22. NAME AND ADDRESS OF FACILITY DeVol Funeral Home 10 E. Deer Park Dr., Gaithersburg, MD 20877 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Metabolic Acidosis DUE TO (OR AS A CONSEQUENCE OF): b. Cerebral arteriosclerosis DUE TO (OR AS A CONSEQUENCE OF): c. _____ DUE TO (OR AS A CONSEQUENCE OF): d. _____ Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Gastrointestinal A-V malformations | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> OOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER  MD | | | | 29c. LICENSE NUMBER 07231 | | 29d. DATE SIGNED (Month, Day, Year) June 29, 1995 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) James R. Morice Jr. 207 Brookes Ave Gaithersburg Md 20877 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JUL 06 1995 | | | | 32. REGISTRAR'S SIGNATURE  | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 21759

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|--|--|---|--|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last) Frederick Jay Brieve | | | | 2. DATE OF DEATH MONTH DAY YEAR June 30, 1995 | | 3. TIME OF DEATH 11:21 A M | |
| 4. SOCIAL SECURITY NUMBER 378-22-7835 | | 5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 66 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) Aug. 17, 1928 | |
| 8. FACILITY NAME (If not institution, give street and number) Washington Adventist Hospital | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Takoma Park | | 9c. COUNTY OF DEATH Montgomery | |
| 10a. STATE Maryland | | | | 10b. COUNTY Montgomery | | 10c. CITY, TOWN OR LOCATION Gaithersburg | |
| 10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | | | | |
| 10e. STREET AND NUMBER 9845 Sailfish Terrace | | | | 10f. ZIP CODE 20879 | | 10g. CITIZEN OF WHAT COUNTRY? United States | |
| 11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES 1951 - 1954 | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Educator | | 16b. KIND OF BUSINESS/INDUSTRY Education | | | |
| 17. FATHER'S NAME (First, Middle, Last) Frank Brieve | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Alice Gebben | | | |
| 19a. INFORMANT'S NAME (Type/Print) Ila C. Brieve | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9845 Sailfish Terrace, Gaithersburg, Maryland 20879 | | | |
| 20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Metropolitan Crematory | | DATE 7/3 | | 20c. LOCATION — City or Town, State Alexandria, Virginia | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Michael D. Gilman</i> | | | | 22. NAME AND ADDRESS OF FACILITY DeVol Funeral Home 10 E. Deer Park Dr., Gaithersburg, MD. 20877 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Thoracic Aortic Aneurysm DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. | | | | | | | Approximate interval Between Onset and Death |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | | | | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/> | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| 29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER Mark A. Magen M.D. | | | | 29c. LICENSE NUMBER D36704 | | 29d. DATE SIGNED (Month, Day, Year) June 30, 1995 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Mark Allen MAZza MD Washington Adventist Hospital 1600 Carroll Avenue TAKOMA PARK, MD 20912 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JUL 06 1995 | | | | 32. REGISTRAR'S SIGNATURE <i>John Shuckor-Hardall</i> | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 21760

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|--|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) GEORGE THOMAS BURLEY | | | | 2. DATE OF DEATH MONTH JULY DAY 1 YEAR 1995 | | 3. TIME OF DEATH 7P M | |
| 4. SOCIAL SECURITY NUMBER 212-34-4445 | | 5. SEX XX M 2 F | | 6. AGE (In yrs. last birthday) 59 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) SEPT. 3-35 | |
| 9a. FACILITY NAME (If not institution, give street and number) ANNE ARUNDEL MEDICAL CENTER | | | | 9b. CITY, TOWN OR LOCATION OF DEATH ANNAPOLIS | | 9c. COUNTY OF DEATH ANNE ARUNDEL | |
| RESIDENCE OF DECEDENT | | | | | | | |
| 10a. STATE MD | | 10b. COUNTY ANNE ARUNDEL | | 10c. CITY, TOWN OR LOCATION LOTHIAN | | 10d. INSIDE CITY LIMITS? 1 YES 2 NO | |
| 10a. STREET AND NUMBER 5570 GREENOCK ROAD (RURAL) | | | | 10f. ZIP CODE 20711 | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 11. MARITAL STATUS X Never Married 2 Married 3 Widowed 4 Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES XXX | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 YES 2 NO XXX Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: BLACK | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 12 | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) LABORER-FARM-TRUCK DRIVER- SCHOOL BUS DRIVER | | 16b. KIND OF BUSINESS/INDUSTRY | | | |
| 17. FATHER'S NAME (First, Middle, Last) CALVERT WESLEY BURLEY | | | | 16. MOTHER'S NAME (First, Middle, Maiden Surname) JOSEPHINE ANN ENNIS BURLEY | | | |
| 19a. INFORMANT'S NAME (Type/Print) JOSEPHINE A. BURLEY | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) SAME AS 10 E | | | |
| 20a. METHOD OF DISPOSITION 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery or other place) MOSES CEM. JULY 7-95 | | DATE | | 20c. LOCATION — City or Town, State DRUDY, MD. | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE CHARLES E. HICKS 111 E. Hicks St. | | | | 21. NAME AND ADDRESS OF FACILITY ANNAPOLIS, MD. 21401 HOUSE OF HICKS 1922 FOREST DRIVE | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | | a. <i>Acute coronary occlusion</i> | | | | | |
| | | b. DUE TO (OR AS A CONSEQUENCE OF): | | | | | |
| | | c. DUE TO (OR AS A CONSEQUENCE OF): | | | | | |
| | | d. DUE TO (OR AS A CONSEQUENCE OF): | | | | | |
| Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Had a stroke years ago. He also had diabetes</i> | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED? 1 YES 2 NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 Inpatient 2 ER/Outpatient 3 DOA OTHER: 4 Nursing Home 5 Residence 6 Other (Specify) | | | | | |
| 27. MANNER OF DEATH 1 Natural 5 Pending Investigation 2 Accident 6 Could not be determined 3 Suicide 4 Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M 1 YES 2 NO | | 28c. INJURY AT WORK? 1 YES 2 NO | |
| | | 28d. DESCRIBE HOW INJURY OCCURRED <i>NO injury</i> | | 28e. LOCATION (Street and Number or Rural Route Number, City or Town, State) <i>5570 Greenock Rd</i> | | | |
| 29a. CERTIFIER (Check only one) 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. SIGNATURE AND TITLE OF CERTIFIER <i>Charles H. Wirth, M.D.</i> | | 29c. LICENSE NUMBER <i>1212412</i> | | 29d. DATE SIGNED (Month, Day, Year) <i>7/5/95</i> | |
| 30. NAME AND ADDRESS OF PERSON WHO SUBMITTED CAUSE OF DEATH (If not 29b) <i>3802 SOLOMONS ISLAND RD. HARWOOD, MD 20776 410-867-3031</i> | | | | | | | |
| 31. DATE FILED (Month, Day, Year) <i>JUL 10 1995</i> | | 32. REGISTRAR'S SIGNATURE <i>Julia Davidson Randall</i> | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

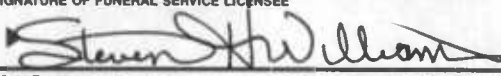


IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Amend #4 7-10-95 Cms

95 21761

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|---|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) Eleanor Bass Berken | | | | 2. DATE OF DEATH MONTH DAY YEAR July 10 1995 | | 3. TIME OF DEATH 7:40 a.m. | |
| 4. SOCIAL SECURITY NUMBER 129-30-80248 | | 5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 86 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) June 24, 1909 | |
| 8. BIRTHPLACE (State or Foreign Country) New York | | 9a. FACILITY NAME (If not institution, give street and number) Crofton Convalescent center | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Crofton | |
| 9c. COUNTY OF DEATH Anne Arundel | | | | 10a. STATE Florida | | | |
| 10b. COUNTY Broward | | 10c. CITY, TOWN OR LOCATION Hallandale | | 10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 10e. STREET AND NUMBER 1849 South Ocean Drive #408 | |
| 10f. ZIP CODE 33009 | | 10g. CITIZEN OF WHAT COUNTRY? USA | | 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | |
| 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: white | | 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 12 | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Homemaker | |
| 16b. KIND OF BUSINESS/INDUSTRY own home | | 17. FATHER'S NAME (First, Middle, Last) Joseph Bass | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Annie Levine | | 19a. INFORMANT'S NAME (Type/Print) Richard Berken | |
| 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2886 Springs Lake Dr., Davidsonville, MD 21035 | | 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Forest Lawn Mem. Gds. South 7/13 | | 20c. LOCATION — City or Town, State Ft. Lauderdale, FL | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE  | | 22. NAME AND ADDRESS OF FACILITY John M. Taylor Funeral Home, Inc. 147 Duke of Gloucester, Annapolis, MD 21401 | | 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <u>Metastatic Cancer - unknown 1^o</u> DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST { b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Approximate Interval Between Onset and Death 6 m | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined | |
| 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED | |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. SIGNATURE AND TITLE OF CERTIFIER  | |
| 29c. LICENSE NUMBER D35848 | | 29d. DATE SIGNED (Month, Day, Year) 7/10/95 | | 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Howard K Schult Jr 1438 Defense Hy Gembills MD 21054 | | 31. DATE FILED (Month, Day, Year) JUL 10 1995 | |
| 32. REGISTRAR'S SIGNATURE  | | | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 21762

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|--|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) VIRGINIA LEE BROOME | | | | 2. DATE OF DEATH MONTH JULY DAY 6 , YEAR 1995 | | 3. TIME OF DEATH 07:00 A M | |
| 4. SOCIAL SECURITY NUMBER 234 58 1584 | | 5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 73 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) Aug 30, 1921 | |
| 8. BIRTHPLACE (State or Foreign Country) WV | | | | 9a. FACILITY NAME (If not institution, give street and number) SACRED HEART HOSPITAL | | 9b. CITY, TOWN OR LOCATION OF DEATH CUMBERLAND | |
| 9c. COUNTY OF DEATH ALLEGANY | | | | 10a. STATE MD | | 10b. COUNTY Allegany | |
| 10c. CITY, TOWN OR LOCATION Oldtown | | | | 10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 10e. STREET AND NUMBER P.O. Box 2 Wilson Road | |
| 10f. ZIP CODE 21555 | | | | 10g. CITIZEN OF WHAT COUNTRY? USA | | 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: white | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (9-12) 12 College (1-4 or 5+) College | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Homemaker | | 16b. KIND OF BUSINESS/INDUSTRY Own Home | |
| 17. FATHER'S NAME (First, Middle, Last) Joseph William McDonald | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Delia Elizabeth (Rinker) | | | |
| 19a. INFORMANT'S NAME (Type/Print) Donald E. Broome | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11816 Bayberry Avenue SW; Cumberland, MD 21502 | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Restlawn Memorial Gardens 07/08 | | 20c. LOCATION — City or Town, State LaVale, MD | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Nicholas J. Scarpelli</i> | | | | 22. NAME AND ADDRESS OF FACILITY Scarpelli Funeral Home Cumberland, MD 21502 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Respiratory failure / pneumonia Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST lung cancer a. DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): | | | | Approximate Interval Between Onset and Death 2 weeks 15 months | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. COPD | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | |
| 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | 28d. DESCRIBE NOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, tectory, office building, etc. (Specify) | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. SIGNATURE AND TITLE OF CERTIFIER <i>Richard G. Schmitt</i> | |
| 29c. LICENSE NUMBER D26333 | | | | 29d. DATE SIGNED (Month, Day, Year) JULY 6, 1995 | | 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) DR. RICHARD SCHMITT, M.D., 900 SETON DRIVE, CUMBERLAND, MD 21502 | |
| 31. DATE FILED (Month, Day, Year) JUL 07 1995 | | | | 32. REGISTRAR'S SIGNATURE <i>Richard R. Carroll</i> | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 21763

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) ADA McCarthy BROWN | | | | 2. DATE OF DEATH MONTH MAY DAY 18 YEAR 1995 | | 3. TIME OF DEATH 4:40 A.M. | |
| 4. SOCIAL SECURITY NUMBER 216-46-4432 | | 5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 84 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) August 6, 1910 | |
| 9a. FACILITY NAME (If not institution, give street and number) Northwest Hospital Center | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Randallstown | | 9c. COUNTY OF DEATH Baltimore | |
| 10a. STATE Texas | | 10b. COUNTY Dallas | | 10c. CITY, TOWN OR LOCATION Dallas | | 10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 10e. STREET AND NUMBER 4242 Lomo Alto | | | | 10f. ZIP CODE 75219 | | 10g. CITIZEN OF WHAT COUNTRY? United States | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Homemaker | | 16b. KIND OF BUSINESS/INDUSTRY Domestic / Own Home | | | |
| 17. FATHER'S NAME (First, Middle, Last) George L. McCarthy | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Elizabeth O'Deal | | | |
| 19a. INFORMANT'S NAME (Type/Print) Jeremy B. Cassels-Smith | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4440 Mt. Zion Road, Upperco, Maryland 21155 | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) St. Pauls Cemetery - May 24, 1995 Chestertown, Maryland | | 20c. LOCATION — City or Town, State | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE William L. King Jr. | | | | 22. NAME AND ADDRESS OF FACILITY Fellows - Wells Funeral Home 413 West High Street - Chestertown, Maryland | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Said's respiratory arrest Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST Myocardial infarction CHF | | | | | | Approximate Interval Between Onset and Death 15 min. 15 min. | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Hyperkalemia, Sepsis | | | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 28. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28d. DESCRIBE HOW INJURY OCCURRED | | | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| 29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER A. J. IMPERIAL, JR. MD | | | | 29c. LICENSE NUMBER D 44505 | | 29d. DATE SIGNED (Month, Day, Year) May 18/95 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) A. J. IMPERIAL, JR. MD, NORTHWEST HOSP. CENTERS | | | | | | | |
| 31. DATE FILED JUN 05 '95 | | 32. REGISTRAR'S SIGNATURE John Davidson-Randall | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

10

BALTIMORE, MARYLAND 21215-0020

P.O. BOX 68760

DIVISION OF VITAL RECORDS

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 21764

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|---|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) ETHEL VIRGINA BOYER | | | | 2. DATE OF DEATH MONTH 6 DAY 1 YEAR 1995 | | 3. TIME OF DEATH 9:00 A.M. | |
| 4. SOCIAL SECURITY NUMBER 208-12-1419 | | 5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 84 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 9-14-1911 | |
| 8. BIRTHPLACE (State or Foreign Country) MD. | | 9a. FACILITY NAME (If not institution, give street and number) AT HER HOME | | 9b. CITY, TOWN OR LOCATION OF DEATH WORTON | | 9c. COUNTY OF DEATH KENT | |
| RESIDENCE OF DECEDENT | | | | | | | |
| 10a. STATE MD. | | 10b. COUNTY KENT | | 10c. CITY, TOWN OR LOCATION WORTON | | 10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 10e. STREET AND NUMBER 11549 STATION R | | | | 10f. ZIP CODE 21678 | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify BLACK | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 0-11 College (1-4 or 5+) | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired) FOOD PROCESSOR | | 16b. KIND OF BUSINESS/INDUSTRY FACTORY | |
| 17. FATHER'S NAME (First, Middle, Last) WILL BOYER | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) EMMA BRIGHT | | | |
| 19a. INFORMANT'S NAME (Type/Print) HOWARD R. POTTS | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11172 POTTS RD. WORTON, MD. 21678 | | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory, or other place) N.C.C. OF LOVE CEM. 6/6/95 | | 20c. LOCATION — City or Town, State WORTON, MD. 21678 | | 20d. DATE 6/6/95 | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Ronald Waller | | | | 22. NAME AND ADDRESS OF FACILITY WALTER FUNERAL HOME WALTERSTOWN, MD. 21620 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → HYPERTENSIVE Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE | | | | | | | Approximate interval Between Onset and Death |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |
| 26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | 27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Nomicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | |
| 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER Harry Paul Ross | | | | 29c. LICENSE NUMBER D10001 | | 29d. DATE SIGNED (Month, Day, Year) 6-5-95 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) HARRY P. ROSS, CHESTERTOWN, MD 21620 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JUN 07 '95 | | | | 32. REGISTRAR'S SIGNATURE Julia Davidson-Randall | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 21765

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) Marian Olive Bailey | | | | 2. DATE OF DEATH MONTH may 26, 1995 YEAR | | 3. TIME OF DEATH 0610 Hrs. | |
| 4. SOCIAL SECURITY NUMBER 221-16-5839 | | 5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 75 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) December 5, 1919 | |
| 8. BIRTHPLACE (State or Foreign Country) Maryland | | | | 9. FACILITY NAME (If not institution, give street and number) 269 North Bohemia Avenue (AT HOME) | | | |
| 10. CITY, TOWN OR LOCATION OF DEATH Cecilton | | | | 11. COUNTY OF DEATH Cecil | | | |
| 12a. STATE Maryland | | 12b. COUNTY Cecil | | 12c. CITY, TOWN OR LOCATION Cecilton | | 12d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 13. STREET AND NUMBER 269 North Bohemia Avenue | | | | 14. ZIP CODE 21913 | | 15. CITIZEN OF WHAT COUNTRY? United States | |
| 16. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 17. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 18. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 19. RACE — American Indian, Black, White, etc. Specify: White | |
| 20. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 9 College (1-4 or 5+) College | | 21. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Rural Route Carrier | | 22. KIND OF BUSINESS/INDUSTRY United States Postal Service | | | |
| 23. FATHER'S NAME (First, Middle, Last) Jerimiah Cosden Price | | | | 24. MOTHER'S NAME (First, Middle, Maiden Surname) Jemie Olive Price | | | |
| 25. INFORMANT'S NAME (Type/Print) Earl L. Bailey | | | | 26. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 269 North Bohemia Avenue, Cecilton, Maryland 21913 | | | |
| 27. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 28. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Cecilton Zion Cemetery - May 30, 1995 | | 29. DATE May 30, 1995 | | 30. LOCATION — City or Town, State Cecilton, Maryland | |
| 31. SIGNATURE OF FUNERAL SERVICE LICENSEE William L. King Jr. | | | | 32. NAME AND ADDRESS OF FACILITY Fellows Funeral Homes, P.A. 226 East Main Street, Cecilton, Maryland | | | |
| 33. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Metastatic Carcinome of the Breast DUE TO (OR AS A CONSEQUENCE OF): SEQUENTIALLY list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| 34. PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | | | | |
| 35. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 36. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 37. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 38a. DATE OF INJURY (Month, Day, Year) | | 38b. TIME OF INJURY M | | 38c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 38d. DESCRIBE HOW INJURY OCCURRED | | 39. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 40. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 41. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 42. SIGNATURE AND TITLE OF CERTIFIER Wallace Obenshain, M.D. | | | | 43. LICENSE NUMBER D 07129 | | 44. DATE SIGNED (Month, Day, Year) May 27, 1995 | |
| 45. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Dr. Wallace Obenshain, M.D. - Chesapeake Family Practice Maryland Route 213, Cecilton, Maryland 21913 | | | | | | | |
| 46. DATE FILED (Month, Day, Year) JUN 01 '95 | | | | 47. REGISTRAR'S SIGNATURE John Davidson-Randall | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

2000-2001

10/1/01

95 21766

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) RICHARD Rhey BENTZ | | | | 2. DATE OF DEATH MONTH JUNE DAY 4 YEAR 1995 | | 3. TIME OF DEATH 9:35 a.m. | |
| 4. SOCIAL SECURITY NUMBER 221-05-2944 | | 5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 77 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) July 27, 1917 | |
| 8. BIRTHPLACE (State or Foreign Country) Pennsylvania | | | | 9a. FACILITY NAME (If not institution, give street and number) GREATER BALTIMORE MEDICAL CENTER | | 9b. CITY, TOWN OR LOCATION OF DEATH TOWSON | |
| 9c. COUNTY OF DEATH BALTIMORE | | | | 10a. STATE Delaware | | 10b. COUNTY Kent | |
| 10c. CITY, TOWN OR LOCATION Cheswald | | | | 10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 10e. STREET AND NUMBER Strimils Park - Post Office Box 243 | |
| 10f. ZIP CODE 19936 | | | | 10g. CITIZEN OF WHAT COUNTRY? United States | | | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES World War II | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (14 or 5+) 5 + | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Band Director / Teacher | | 16b. KIND OF BUSINESS/INDUSTRY Musical Education | | | |
| 17. FATHER'S NAME (First, Middle, Last) William Mervin Bentz | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Florence Nevada Bentz | | | |
| 19a. INFORMANT'S NAME (Type/Print) Mrs. Sheila E. Bentz | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) Strimils Park - Post Office Box 243, Cheswald, Delaware 19936 | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory, or other place) Chestertown Cemetery - June 8, 1995 | | 20c. LOCATION — City or Town, State Centreville, Maryland | | 21. SIGNATURE OF FUNERAL SERVICE LICENSEE William L. King Jr. | |
| 22. NAME AND ADDRESS OF FACILITY Fellows - Wells Funeral Home 413 West High Street, Chestertown, Maryland 21620 | | 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Ventricular Tachycardia DUE TO (OR AS A CONSEQUENCE OF): b. Ischemic Cardiomyopathy DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Approximate Interval Between Onset and Death 10 min 5 yrs. | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | | | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | |
| 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28e. DESCRIBE HOW INJURY OCCURRED | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER John K. Portenfield, M.D. | | | | 29c. LICENSE NUMBER D30948 | | 29d. DATE SIGNED (Month, Day, Year) 6/4/95 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) JK Portenfield, M.D. GBMC | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JUN 09 '95 | | | | 32. REGISTRAR'S SIGNATURE John Davidson | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.




TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | | | | | | | | | | | | |
|--|--|---|--|---|--|---|---|---|--|---|--|---------------------------------------|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) JAMES ANDREW BOYLE | | | | 2. DATE OF DEATH MONTH JULY DAY 13 YEAR 1995 | | 3. TIME OF DEATH 1435 P M | | | | | | | | | |
| 4. SOCIAL SECURITY NUMBER 214-31-4915 | | 5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 8. AGE (In yrs. last birthday) 4 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) Nov. 26, 1990 | | 8. BIRTHPLACE (State or Foreign Country) Maryland | | | | | | | |
| 9a. FACILITY NAME (If not institution, give street and number) UNION HOSPITAL | | | | 9b. CITY, TOWN OR LOCATION OF DEATH ELKTON | | | 9c. COUNTY OF DEATH CECIL | | | | | | | | |
| 10a. STATE Maryland | | 10b. COUNTY Cecil | | 10c. CITY, TOWN OR LOCATION Colora | | | | 10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | | | | | | |
| 10e. STREET AND NUMBER 372 Harrisville Road | | | | 10f. ZIP CODE 21917 | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | | | | | | | | | |
| 11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | | 14. RACE — American Indian, Black, White, etc. Specify: White | | | | | | | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) n/a College (1-4 or 5+) n/a | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) n/a | | | 16b. KIND OF BUSINESS/INDUSTRY | | | | | | | | |
| 17. FATHER'S NAME (First, Middle, Last) James Frederick Boyle | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Tammy Elaine Kendall | | | | | | | | | | | |
| 19a. INFORMANT'S NAME (Type/Print) Tammy Boyle | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 372 Harrisville Road - Colora, MD 21917 | | | | | | | | | | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Gilpin Manor Memorial Park 1995 | | | 20c. LOCATION — City or Town, State Elkton, Maryland | | | | | | | | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE  | | | | 22. NAME AND ADDRESS OF FACILITY Hicks Home for Funerals, P.A. 103 West Stockton Street Elkton, MD 21921-5521 | | | | | | | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. MULTIPLE INJURIES DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | | | Approximate interval Between Onset and Death | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO | | | | | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | | | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | | | | | | | |
| 27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input checked="" type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) 7-13-95 | | 28b. TIME OF INJURY 1:48 P M | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED SUBJECT STRUCK BY A PICK-UP TRUCK | | | | | | | |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) STREET | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) COTTONWOOD LANE PORT DEPOSIT, MD. | | | | | | | | | | | |
| 29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | | 29b. SIGNATURE AND TITLE OF CERTIFIER  | | 29c. LICENSE NUMBER O.C.M.E | | 29d. DATE SIGNED (Month, Day, Year) JULY 14, 1995 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (Item 27) (Type, Print) MARIO F. GOLLE JR MD 111 Penn Street, Baltimore, Maryland 21201 | | | | | | | | | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JUL 19 1995 | | | | 32. REGISTRAR'S SIGNATURE  | | | | | | | | | | | |

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

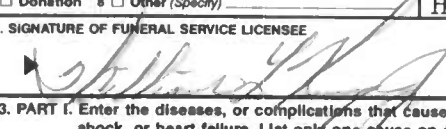
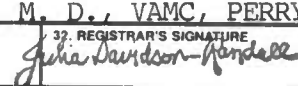
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95 21768

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) Harry W. Coleman | | | | 2. DATE OF DEATH MONTH June DAY 14 YEAR 1995 | | 3. TIME OF DEATH 4:05PM | |
| 4. SOCIAL SECURITY NUMBER 218-16-8151 | | 5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 69 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) December 14, 1925 Maryland | |
| 8a. FACILITY NAME (If not institution, give street and number) Perry Point Veterans Administration Hospital | | | | 8b. CITY, TOWN OR LOCATION OF DEATH Perry Point | | 8c. COUNTY OF DEATH Cecil | |
| RESIDENCE OF DECEDENT | | | | | | | |
| 10a. STATE Maryland | | 10b. COUNTY Queen Annes | | 10c. CITY, TOWN OR LOCATION Chestertown | | 10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 10e. STREET AND NUMBER 835 Woods Road | | | | 10f. ZIP CODE 21620 | | 10g. CITIZEN OF WHAT COUNTRY? United States | |
| 11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES World War II | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 8 | | 15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Automechanic | | 16b. KIND OF BUSINESS/INDUSTRY Auto Repair | | | |
| 17. FATHER'S NAME (First, Middle, Last) William W. Coleman | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Lena A. Bryan | | | |
| 19a. INFORMANT'S NAME (Type/Print) Dennis W. Coleman | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 835 Woods Road, Chestertown, Maryland 21620 | | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Hurlock Veterans Cemetery - June 19, 1995 Hurlock, Maryland | | 20c. LOCATION — City or Town, State | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE  | | | | 22. NAME AND ADDRESS OF FACILITY FELLOWS - WALLS FUNERAL HOME CHESTERTOWN, MD 21620 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | | | | | | | |
| a. Bacteremia DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| b. Secondary to Escherichia Coli DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| c. Streptococcus Agalactiae DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| d. | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Multi-Infarct Dementia Diabetes Mellitus | | | | | | | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER Melecia Santos, MD | | | | 29c. LICENSE NUMBER 151094-1 | | 29d. DATE SIGNED (Month, Day, Year) 6-14-95 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) MELECIA SANTOS, M. D., VAMC, PERRY POINT, MD., 21902 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JUN 15 '95 | | | | 32. REGISTRAR'S SIGNATURE  | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 21769

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|---|--|--|--|--|--|
| 1. DECEASED'S NAME (First, Middle, Last) Howard Morton Cole | | | | 2. DATE OF DEATH MONTH DAY YEAR June 9, 1995 | | 3. TIME OF DEATH P M 4:17 | |
| 4. SOCIAL SECURITY NUMBER 202-18-6965 | | 5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 67 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) July 7, 1927 | |
| 8. BIRTHPLACE (State or Foreign Country) Pennsylvania | | | | 9a. FACILITY NAME (If not institution, give street and number) The Kent and Queen Anne's Hospital, Inc. | | 9b. CITY, TOWN OR LOCATION OF DEATH Chestertown | |
| 9c. COUNTY OF DEATH Kent | | | | 10a. STATE Maryland | | 10b. COUNTY Kent | |
| 10c. CITY, TOWN OR LOCATION Chestertown | | | | 10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | 10e. STREET AND NUMBER 110 Elm St. | |
| 10f. ZIP CODE 21620 | | | | 10g. CITIZEN OF WHAT COUNTRY? USA | | 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White | |
| 15. DECEASED'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 12 | | | | 16a. DECEASED'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Co-Owner of Shoe Store | | 16b. KIND OF BUSINESS/INDUSTRY Sales | |
| 17. FATHER'S NAME (First, Middle, Last) H. Lee Cole | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Helen McMacken | | | |
| 19a. INFORMANT'S NAME (Type/Print) Anna E. Cole | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 110 Elm. St., Chestertown, Md. 21620 | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Crumpton Cemetery June 12, 95 | | 20c. LOCATION — City or Town, State Crumpton, Md. | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Gay B. Tillman</i> | | | | 22. NAME AND ADDRESS OF FACILITY Fellows - Wells Funeral Home 413 High St. Chestertown, Md. 21620 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <i>Electromechanical Dissociation</i> DUE TO (OR AS A CONSEQUENCE OF): b. <i>Congestive Heart Failure</i> DUE TO (OR AS A CONSEQUENCE OF): c. <i>Dilated Left Ventricle</i> DUE TO (OR AS A CONSEQUENCE OF): d. <i>Atherosclerotic Heart Disease</i> Approximate Interval Between Onset and Death 20 min 24 hr 2 yrs 5 yrs | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER <i>George M. Young</i> | | | | 29c. LICENSE NUMBER D31979 | | 29d. DATE SIGNED (Month, Day, Year) June 9 1995 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type/Print) GEORGE M. YOUNG MD | | | | 31. DATE FILED (Month, Day, Year) JUN 15 '95 | | | |
| 32. REGISTRAR'S SIGNATURE <i>John Burdick</i> | | | | 33. REGISTRAR'S NAME John Burdick | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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95 21770

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) Willard Joseph Conlon | | | | 2. DATE OF DEATH MONTH 7 DAY 2 YEAR '95 | | 3. TIME OF DEATH 12:35 AM | |
| 4. SOCIAL SECURITY NUMBER 579-58-4879 | | 5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 93 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) June 2, 1902 | |
| 9a. FACILITY NAME (If not institution, give street and number) CARRIAGE HILL Silver Spring | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Silver Spring, md. | | 9c. COUNTY OF DEATH Montgomery | |
| 10a. STATE Maryland | | 10b. COUNTY Montgomery | | 10c. CITY, TOWN OR LOCATION Silver Spring | | 10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | |
| 10e. STREET AND NUMBER 10013 Raynor Road | | | | 10f. ZIP CODE 20901 | | 10g. CITIZEN OF WHAT COUNTRY? USA | |
| 11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No - If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE - American Indian, Black, White, etc. Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) College | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Auditor | | 16b. KIND OF BUSINESS/INDUSTRY U.S. Government | | | |
| 17. FATHER'S NAME (First, Middle, Last) Mark Conlon | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Margaret Creaney | | | |
| 19a. INFORMANT'S NAME (Type/Print) Francis j. Conlon | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10013 Raynor Road, Silver Spring, MD 20901 | | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Gate of Heaven Cemetery 7/7/95 | | 20c. LOCATION - City or Town, State Silver Spring, MD | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | | | | 22. NAME AND ADDRESS OF FACILITY Francis J. Collins Funeral Home, Inc 500 University Blvd. W. Sil. Spr. MD 20901 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | | a. Resp. ARREST DUE TO (OR AS A CONSEQUENCE OF): b. ASPIRATION PNEUMONIA DUE TO (OR AS A CONSEQUENCE OF): c. STROKE DUE TO (OR AS A CONSEQUENCE OF): d. | | | | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | e. PROSTATE CA f. | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/> | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| | | 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. PLACE OF INJURY - At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. SIGNATURE AND TITLE OF CERTIFIER | | 29c. LICENSE NUMBER D36046 | | 29d. DATE SIGNED (Month, Day, Year) 7/2/95 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 7701 RANDOLPH RD #216 ROCKVILLE, MD 20852 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JUL 07 1995 | | 32. REGISTRAR'S SIGNATURE | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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95 21771

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) Charles Curtis Cherry | | | | 2. DATE OF DEATH July 4 th , 1995 | | 3. TIME OF DEATH 2:15 PM | |
| 4. SOCIAL SECURITY NUMBER 579-19-3421 | | 5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 71 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) Jan. 16, 1924 | |
| 8. BIRTHPLACE (State or Foreign Country) Washington, D.C. | | | | 9a. FACILITY NAME (If not institution, give street and number) Suburban Hospital | | 9b. CITY, TOWN OR LOCATION OF DEATH Bethesda | |
| 9c. COUNTY OF DEATH Montgomery | | | | 10a. STATE Maryland | | 10b. COUNTY Montgomery | |
| 10c. CITY, TOWN OR LOCATION Kensington | | | | 10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 10e. STREET AND NUMBER 4219 Knowles Avenue | |
| 10f. ZIP CODE 20895 | | | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | | 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced | |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES WW II | | | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (14 or 5+) 12 | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Furniture Refinisher | | 16b. KIND OF BUSINESS/INDUSTRY Furniture | |
| 17. FATHER'S NAME (First, Middle, Last) Purcellville Cherry | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Elizabeth Dangler | | | |
| 19a. INFORMANT'S NAME (Type/Print) Mary Ann Waelde | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 14700 Notley Road Silver Spring, Maryland 20905 | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Gate of Heaven Cemetery 07/07/95 | | 20c. LOCATION — City or Town, State Silver Spring, Maryland | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Mark S. Dillman</i> | | | | 22. NAME AND ADDRESS OF FACILITY Francis J. Collins Funeral Home, Inc. 500 University Blvd., W. Sil. Spr., MD 20901 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. MYOCARDIAL INFARCTION Due to (or as a consequence of): b. DIABETES MELLITUS Due to (or as a consequence of): c. _____ Due to (or as a consequence of): d. _____ Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. RENAL FAILURE, HEPATIC CARCINOMA DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER <i>BACKOWSKI, MD</i> | | | | 29c. LICENSE NUMBER D35370 | | 29d. DATE SIGNED (Month, Day, Year) 04 JUL 1995 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) TAN BACKOWSKI 11125 ROCKVILLE PIKE | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JUL 07 1995 | | | | 32. REGISTRAR'S SIGNATURE <i>John Davidson Randall</i> | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

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5+1

95 21772

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) ELSIE VIRGINIA CURTIS | | | | 2. DATE OF DEATH MONTH JULY DAY 1 YEAR 1995 | | 3. TIME OF DEATH 8:20 A M | |
| 4. SOCIAL SECURITY NUMBER 220-76-6790 | | 5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 74 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) Feb. 13, 1921 | |
| 9a. FACILITY NAME (If not institution, give street and number) 2924 Bel Pre Road | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Silver Spring | | 9c. COUNTY OF DEATH Montgomery | |
| 10a. STATE Maryland | | | | 10b. COUNTY Montgomery | | 10c. CITY, TOWN OR LOCATION Silver Spring | |
| 10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | | | | |
| 10e. STREET AND NUMBER 11901 Colin Road | | | | 10f. ZIP CODE 20906 | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 9 College (1-4 or 5+) | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Homemaker | | 16b. KIND OF BUSINESS/INDUSTRY Own Home | | | |
| 17. FATHER'S NAME (First, Middle, Last) Charles Pugh | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Blanche Walker | | | |
| 19a. INFORMANT'S NAME (Type/Print) Janet D. Castellow | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11901 Colin Road Silver Spring, Maryland 20906 | | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Potomac 7/5/95 United Methodist Ch. Cemetery | | 20c. LOCATION — City or Town, State Potomac, Maryland | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Steven A. Stindel | | | | 22. NAME AND ADDRESS OF FACILITY Francis J. Collins Funeral Home, Inc. 500 University Blvd., W. Sil. Spr., MD 20901 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → SUSPECTED Pulmonary Embolus Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Approximate interval between Onset and Death 10 min | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. COPD - Severe | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO | | | | | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 28d. DESCRIBE NOW INJURY OCCURED | | | | 28e. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER Typed Name | | | | 29c. LICENSE NUMBER D 21340 | | 29d. DATE SIGNED (Month, Day, Year) July 3, 1995 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) RAYMOND BASS 15225 Shady Grove Rd Rockville MD 20850 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JUL 05 1995 | | 32. REGISTRAR'S SIGNATURE Julia Davidson-Randall | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 5 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 21773

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) Carrie S Chaffin | | | | 2. DATE OF DEATH MONTH July DAY 1 YEAR 1995 | | 3. TIME OF DEATH 9A M | |
| 4. SOCIAL SECURITY NUMBER 579 05 8142 | | 5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 99 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) Sept. 10, 1895 | |
| 9a. FACILITY NAME (If not institution, give street and number) 6030 Sargent Rd. Apt. #3208 | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Hyattsville | | 9c. COUNTY OF DEATH Prince George's | |
| RESIDENCE OF DECEDENT | | | | | | | |
| 10a. STATE Maryland | | 10b. COUNTY Prince George's | | 10c. CITY, TOWN OR LOCATION Hyattsville | | 10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | |
| 10e. STREET AND NUMBER 6030 Sargent Rd. Apt. #3208 | | | | 10f. ZIP CODE 20782 | | 10g. CITIZEN OF WHAT COUNTRY? United States | |
| 11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: Black | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (1-4 or 5+) College | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Elevator Operator | | 16b. KIND OF BUSINESS/INDUSTRY Parker Apartments | | | |
| 17. FATHER'S NAME (First, Middle, Last) Charles Stewart | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Mary Catherine Austin | | | |
| 19a. INFORMANT'S NAME (Type/Print) Cecile C. Jefferson | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6030 Sargent Rd., #3208, Hyattsville, MD. 20782 | | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Lincoln Memorial Cem. 7/5/95 | | 20c. LOCATION — City or Town, State Suitland, MD. | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Harold E. Harts</i> | | | | 22. NAME AND ADDRESS OF FACILITY McGuire Funeral Service Inc. 20012 7400 Georgia Ave., N.W., Washington, D.C. | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Chronic renal failure DUE TO (OR AS A CONSEQUENCE OF): Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. | | | | | | | Approximate Interval Between Onset and Death |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Arthritis (severe), U.T.I. | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| | | 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER <i>Augusto L. Rodriguez MD</i> | | | | 29c. LICENSE NUMBER D 212 30 | | 29d. DATE SIGNED (Month, Day, Year) July 2, 1995 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Augusto L. Rodriguez MD, 5009 Rayburn Ct. C. & S. Md 20748 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JUL 05 1995 | | 32. REGISTRAR'S SIGNATURE <i>John Davidson Randall</i> | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

68760

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 21774

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|---|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) Walter Melvin Cameron, Jr. | | | | 2. DATE OF DEATH MONTH DAY YEAR July 2 1995 | | 3. TIME OF DEATH 4:25 p M | |
| 4. SOCIAL SECURITY NUMBER 231-74-0142 | | 5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 44 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) Oct. 20, 1950 | |
| 8. FACILITY NAME (If not institution, give street and number) 118 Duvall Lane #303 | | | | 9a. CITY, TOWN OR LOCATION OF DEATH Gaithersburg | | 9b. COUNTY OF DEATH Montgomery | |
| 10a. STATE Maryland | | | | 10b. COUNTY Montgomery | | 10c. CITY, TOWN OR LOCATION Gaithersburg | |
| 10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | | | | |
| 10e. STREET AND NUMBER 118 Duvall Lane #303 | | | | 10f. ZIP CODE 20877 | | 10g. CITIZEN OF WHAT COUNTRY? United States | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 12 | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Hydrolic Lift Installer | | 16b. KIND OF BUSINESS/INDUSTRY Automotive | | | |
| 17. FATHER'S NAME (First, Middle, Last) Walter Melvin Cameron, Sr. | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Betty Lou Yocum | | | |
| 19a. INFORMANT'S NAME (Type/Print) Virginia Raftery Cameron | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 118 Duvall Lane #303, Gaithersburg, MD 20877 | | | |
| 20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Metropolitan Crematory 7/6/95 | | 20c. LOCATION — City or Town, State Alexandria, Virginia | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Michael D. Hibbons | | | | 22. NAME AND ADDRESS OF FACILITY DeVol Funeral Home 10 East Deer Park Drive Gaithersburg, MD 20877 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Carcinoma of the Lung Mestatic DUE TO (OR AS A CONSEQUENCE OF): b. To Liver, Bone & Brain DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST | | | | | | Approximate Interval Between Onset and Death 6 Months | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 6 <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER DeVol Funeral Home | | | | 29c. LICENSE NUMBER D06959 | | 29d. DATE SIGNED (Month, Day, Year) 7/3/95 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Elisa Martinez, MD, 8808 Hidden Hill Lane, Potomac, MD | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JUL 06 1995 | | | | 32. REGISTRAR'S SIGNATURE Julia Davidson Randall | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 21775

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|--|--|--|---|
| 1. DECEDENT'S NAME (First, Middle, Last) EDWIN BERNARD COYL | | | | 2. DATE OF DEATH MONTH DAY YEAR JUNE 28 1995 | | 3. TIME OF DEATH 5:10 a.m. | |
| 4. SOCIAL SECURITY NUMBER 215 38 9660 | | 5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 90 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) July 31, 1904 | |
| 8. BIRTHPLACE (State or Foreign Country) Washington D.C. | | | | 9. FACILITY NAME (If not institution, give street and number) NATIONAL NAVAL MEDICAL CENTER | | 10. CITY, TOWN OR LOCATION OF DEATH BETHESDA | |
| 11. RESIDENCE OF DECEDENT 10a. STATE Maryland | | | | 10b. COUNTY Montgomery | | 10c. CITY, TOWN OR LOCATION Potomac | |
| 10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | 10e. STREET AND NUMBER 8713 Wandering Trail Drive | | 10f. ZIP CODE 20854 | |
| 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | | | | 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES WWII, KOREAN | |
| 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | | | 14. RACE — American Indian, Black, White, etc. Specify: WHITE | | 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) +5 College (1-4 or 5+) +5 | |
| 16. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) MEDICAL DOCTOR | | | | 17. KIND OF BUSINESS/INDUSTRY MEDICINE | | | |
| 17. FATHER'S NAME (First, Middle, Last) CLINTON COYL | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) EDNA | | | |
| 19a. INFORMANT'S NAME (Type/Print) BETTY BUCK | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8713 WANDERING TRAIL DR. POTOMAC, MD. 20854 | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) ARLINGTON NAT. CEMETERY 7/6 | | 20c. LOCATION — City or Town, State ARLINGTON, VIRGINIA | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>John M. Peters</i> | | | | 22. NAME AND ADDRESS OF FACILITY JOSEPH GAWLERS SONS 5130 WI AVE NW WASHINGTON DC 20016 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. MASSIVE HYPERTENSIVE BLEED DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST | | | | | | | Approximate Interval Between Onset and Death |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | | | | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER A. A. HOCUTT LT, MC, USNR | | | | 29c. LICENSE NUMBER TN MD-0000025807 | | 29d. DATE SIGNED (Month, Day, Year) JUNE 28, 1995 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) A. A. HOCUTT LT, MC, USNR | | | | 31. DATE FILED (Month, Day, Year) JUL 06 1995 | | | |
| 32. REGISTRAR'S SIGNATURE Julia Davidson-Randall | | | | 33. NATIONAL NAVAL MEDICAL CENTER BETHESDA, MD 20889-5600 | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 21776

ITEM: 2. PER DR. FILM G-726 8/18/95 t.t

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|---|--|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last) Nicholas Joseph Conte, Sr. | | | | 2. DATE OF DEATH MONTH <u>JULY</u> DAY <u>3</u> YEAR <u>1995</u> | | 3. TIME OF DEATH <u>5:52P</u> M | |
| 4. SOCIAL SECURITY NUMBER 578-50-0414 | | 5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 55 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) Feb 2 1940 | |
| 9a. FACILITY NAME (If not institution, give street and number) Calvert Memorial Hospital | | 9b. CITY, TOWN OR LOCATION OF DEATH Prince Frederick | | 9c. COUNTY OF DEATH Calvert | | | |
| 10a. STATE MD | | 10b. COUNTY Anne Arundel | | 10c. CITY, TOWN OR LOCATION Bristol | | 10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 10e. STREET AND NUMBER 1031 Wrighton Road | | | | 10f. ZIP CODE 20728 | | 10g. CITIZEN OF WHAT COUNTRY? United States | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: <u>White</u> | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <u>12</u> College (1-4 or 5+) <u></u> | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Contractor/Builder | | 16b. KIND OF BUSINESS/INDUSTRY Construction | | | |
| 17. FATHER'S NAME (First, Middle, Last) Anthony S. Conte | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Esther Procopio | | | |
| 19a. INFORMANT'S NAME (Type/Print) Carol C. Conte | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1031 Wrighton Road Bristol, Maryland 20728 | | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <u>Resurrection Cemetery 7/6/95</u> | | 20c. LOCATION — City or Town, State <u>Clinton, Maryland</u> | | 20d. DATE <u>7/6/95</u> | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Ronald J. Taylor</i> | | | | 22. NAME AND ADDRESS OF FACILITY John M. Taylor Funeral Home 147 Duke of Gloucester St. Annapolis, MD | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <u>Acute Myocardial Infarction</u> DUE TO (OR AS A CONSEQUENCE OF): <u>Hypercholesterolemia</u> DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | | Approximate Interval Between Onset and Death |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>Diabetes Mellitus</u> | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | | | | 24c. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/> |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 28d. DESCRIBE NOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER <i>Katherine M. Sanzaro MD</i> | | | | 29c. LICENSE NUMBER <u>D26873</u> | | 29d. DATE SIGNED (Month, Day, Year) <u>7 5 95</u> | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <u>5804 Baltimore Ave Hyattsville MD 20781</u> | | | | | | | |
| 31. DATE FILED (Month, Day, Year) <u>JUL 10 1995</u> | | | | 32. REGISTRAR'S SIGNATURE <i>John Andrew Randall</i> | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 21777

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) AGNES IRENE COATES | | | | 2. DATE OF DEATH MONTH JULY 06, DAY 1995 YEAR | | 3. TIME OF DEATH 11:30 P. M. | |
| 4. SOCIAL SECURITY NUMBER 216-24-4736 | | 5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 8. AGE (In yrs. last birthday) 34 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) April 8, 1960 | |
| 9a. FACILITY NAME (If not institution, give street and number) PHYSICIANS MEMORIAL HOSPITAL | | | | 9b. CITY, TOWN OR LOCATION OF DEATH LA PLATA | | 9c. COUNTY OF DEATH CHARLES | |
| 10a. STATE Maryland | | | | 10b. COUNTY Charles | | 10c. CITY, TOWN OR LOCATION Bryantown | |
| 10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | 10e. STREET AND NUMBER P.O. Box 163 | | 10f. ZIP CODE 20617 | |
| 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | | | | 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | |
| 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | | | 14. RACE — American Indian, Black, White, etc. Specify: Black | | 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 12 | |
| 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Homemaker | | | | 16b. KIND OF BUSINESS/INDUSTRY Domestic | | 17. FATHER'S NAME (First, Middle, Last) Edward Coates | |
| 18. MOTHER'S NAME (First, Middle, Maiden Surname) Annie T. Young | | | | 19a. INFORMANT'S NAME (Type/Print) Annie T. Young | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) P.O. Box 163, Bryantown Maryland 20617 | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) St. Marys Cath. Ch 7/11/95 | | 20c. LOCATION — City or Town, State Bryantown, Maryland | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Lloyd M. Estep | | | | 22. NAME AND ADDRESS OF FACILITY Adams Funeral Home, Aquasco MD 20608 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Pneumonia in left lung b. Due to (or as a consequence of): Sepsis c. Due to (or as a consequence of): Cerebral Palsy d. Due to (or as a consequence of): Osteoporosis Approximate Interval Between Onset and Death | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined | | | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 28c. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28d. DESCRIBE HOW INJURY OCCURRED | | | |
| 28e. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER John A. [Signature] | | | | 29c. LICENSE NUMBER D20629 | | 29d. DATE SIGNED (Month, Day, Year) 7/7/95 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) John A. [Signature] - LA PLATA - MD 20646 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JUL 11 1995 | | | | 32. REGISTRAR'S SIGNATURE John A. [Signature] | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 21778

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|---|--|---|--|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last) Don Clark | | | | 2. DATE OF DEATH MONTH July DAY 9, 1995 YEAR | | 3. TIME OF DEATH 4:58 A M | |
| 4. SOCIAL SECURITY NUMBER 216-12-4681 | | 5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 73 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) April 2, 1922 | |
| 8. BIRTHPLACE (State or Foreign Country) Maryland | | | | 9a. FACILITY NAME (If not institution, give street and number) Physicians Memorial Hospital | | 9b. CITY, TOWN OR LOCATION OF DEATH La Plata | |
| 9c. COUNTY OF DEATH Charles | | | | 10a. STATE Maryland | | 10b. COUNTY Charles | |
| 10c. CITY, TOWN OR LOCATION Newburg | | | | 10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | |
| 10e. STREET AND NUMBER 11165 Little How Place | | | | 10f. ZIP CODE 20664 | | 10g. CITIZEN OF WHAT COUNTRY? United States | |
| 11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: Black | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 6 College (1-4 or 5+) | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Oiler | | 16b. KIND OF BUSINESS/INDUSTRY N.O.S "Gov." | | | |
| 17. FATHER'S NAME (First, Middle, Last) John Lindsey Clark | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Mary Rebecca (Carroll) Clark | | | |
| 19a. INFORMANT'S NAME (Type/Print) Donnie Butler | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11165 Little How Place, Newburg, MD 20664 | | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Shiloh Comm. Un. Meth. Ceme. 7/12/95 | | 20c. LOCATION — City or Town, State Newburg, MD | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Leon Thornton | | | | 22. NAME AND ADDRESS OF FACILITY THORNTON FUNERAL HOME INDIAN HEAD, MARYLAND | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <u>Carcinoma of Stomach</u> DUE TO (OR AS A CONSEQUENCE OF): b. <u>Severe Anemia</u> DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | | Approximate Interval Between Onset and Death |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>Respiratory Insufficiency, pleural effusion</u> | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO | | | | | | | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/> | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| | | 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER Song Chol Chon, M.D. | | | | 29c. LICENSE NUMBER D-37174 | | 29d. DATE SIGNED (Month, Day, Year) 7/10/95 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Song Chol Chon, M.D. 7C Post Office Road, Cenna Center Waldorf, Maryland 20602 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JUL 11 1995 | | | | 32. REGISTRAR'S SIGNATURE John Davidson Randall | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 21779

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) FRED CHAMBERS | | | | 2. DATE OF DEATH MONTH JULY DAY 8 YEAR 1995 | | 3. TIME OF DEATH APPRX 4:05 P. | |
| 4. SOCIAL SECURITY NUMBER 133-28-5090 | | 5. SEX 1 <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 62 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) SEPT 12 1932 NC. | |
| 9a. FACILITY NAME (If not institution, give street and number) 355 S. DEEN STREET | | | | 9b. CITY, TOWN OR LOCATION OF DEATH ABERDEEN | | 9c. COUNTY OF DEATH HARFORD | |
| RESIDENCE OF DECEDENT | | | | | | | |
| 10a. STATE MD | | 10b. COUNTY HARFORD | | 10c. CITY, TOWN OR LOCATION ABERDEEN | | 10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | |
| 10e. STREET AND NUMBER 355 S. DEEN STREET | | | | 10f. ZIP CODE 21001 | | 10g. CITIZEN OF WHAT COUNTRY? USA | |
| 11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. BLACK | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) G.E.D. | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) HIGHWAY CONST. COUNTY GOVERN. | | 16b. KIND OF BUSINESS/INDUSTRY | | | |
| 17. FATHER'S NAME (First, Middle, Last) KENNETH CHAMBERS | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) MOLLIE WESTON | | | |
| 19a. INFORMANT'S NAME (Type/Print) VIRGINIA CHAMBERS | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 355 S. DEEN ST. ABERDEEN, MD 21001 | | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) COMMUNITY BAPT. CH. CH. 7/14 JOPPA, MD | | 20c. LOCATION — City or Town, State | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | | | | 22. NAME AND ADDRESS OF FACILITY BENED FUNERAL HOME 2078 252 LEWIS ST. WADE DE LAKE | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → CONGESTIVE HEART FAILURE | | | | | | | |
| DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| a. DILATED CARDIOMYOPATHY | | | | | | | |
| DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| c. ARTERIOSCLEROTIC HEART DISEASE | | | | | | | |
| DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| d. | | | | | | | |
| Approximate Interval Between Onset and Death 2 yrs - 3 yrs - 6 yrs - | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input type="checkbox"/> NO | | | | | | | |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO | | | | | | | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| | | 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER | | | | 29c. LICENSE NUMBER D 15994 | | 29d. DATE SIGNED (Month, Day, Year) 7/10/95 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JUL 11 1995 | | | | 32. REGISTRAR'S SIGNATURE | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) John Leroy Casson | | | | 2. DATE OF DEATH MONTH July DAY 3 YEAR 1995 | | 3. TIME OF DEATH 2:30 P M | |
| 4. SOCIAL SECURITY NUMBER 212-32-1056 | | 5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 92 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) May 16, 1903 | |
| 9a. FACILITY NAME (If not institution, give street and number) Union Hospital of Cecil County | | 9b. CITY, TOWN OR LOCATION OF DEATH Elkton | | | | 9c. COUNTY OF DEATH Cecil | |
| RESIDENCE OF DECEDENT | | | | | | | |
| 10a. STATE Maryland | | 10b. COUNTY Cecil | | 10c. CITY, TOWN OR LOCATION Elkton | | 10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | |
| 10e. STREET AND NUMBER 616 Delaware Avenue | | | | 10f. ZIP CODE 21921 | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES 1920 - 1922 | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 7 College (1-4 or 5+) College | | 15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Truck Driver | | 15b. KIND OF BUSINESS/INDUSTRY Transportation | | | |
| 17. FATHER'S NAME (First, Middle, Last) George A. Casson | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Ida Butler | | | |
| 19a. INFORMANT'S NAME (Type/Print) Margaret E. Casson | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 616 Delaware Avenue - Elkton, MD 21921 | | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Bethel Cemetery 7/3/95 | | 20c. LOCATION — City or Town, State Chesapeake City, MD | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Donna E. Hicks</i> | | | | 22. NAME AND ADDRESS OF FACILITY Hicks Home for Funerals, P.A. 103 West Stockton Street Elkton, MD 21921-5521 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | | a. Septic Shock | | | | Approximate interval Between Onset and Death 24 hrs | |
| Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST | | b. Dehydration - Malnutrition | | | | b. 16 hrs | |
| | | c. Chronic Obstructive Pulmonary Disease | | | | c. Many years | |
| | | d. Dementia | | | | | |
| | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Pacemaker for Complete AV Block | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| 29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER <i>Jayantilal K. Patel MD</i> | | | | 29c. LICENSE NUMBER D22307 | | 29d. DATE SIGNED (Month, Day, Year) 7/3/95 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) JAYANTILAL K. PATEL MD 123 SINGERLY AVE ELKTON MD 21921 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JUL 08 1995 | | | | 32. REGISTRAR'S SIGNATURE <i>John Davidson</i> | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 21781

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) William Timothy Cann | | | | 2. DATE OF DEATH MONTH May 26 DAY 1995 YEAR | | 3. TIME OF DEATH 8:34 A M | |
| 4. SOCIAL SECURITY NUMBER 213-42-0998 | | 5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 51 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 9-19-43 | |
| 8. BIRTHPLACE (State or Foreign Country) Maryland | | | | 9a. FACILITY NAME (If not institution, give street and number) The Memorial Hospital | | 9b. CITY, TOWN OR LOCATION OF DEATH Easton, Md. | |
| 9c. COUNTY OF DEATH Talbot | | | | 10a. STATE Maryland | | 10b. COUNTY Kent | |
| 10c. CITY, TOWN OR LOCATION Chestertown | | | | 10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 10e. STREET AND NUMBER 309 Roosevelt Drive | |
| 10f. ZIP CODE 21620 | | | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | | 11. FATHER'S NAME (First, Middle, Last) Arthur Cann | |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: Black | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 th | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Laborer | | 16b. KIND OF BUSINESS/INDUSTRY Construction | |
| 17. MOTHER'S NAME (First, Middle, Maiden Surname) Emma Tilghman Cann | | | | 18a. INFORMANT'S NAME (Type/Print) Jacqueline Cann | | 18b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 309 Roosevelt Dr. - Chestertown, Md. 21620 | |
| 19a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 19b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) James Cemetery 6-1-95 | | 19c. LOCATION — City or Town, State Chestertown, Md. | |
| 20. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>James A. Perkins</i> | | | | 21. NAME AND ADDRESS OF FACILITY James A. Perkins Funeral Service P.O. Box 143 - Rock Hall, Md. 21661 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | | a. <i>urinary tract infection with sepsis</i> DUE TO (OR AS A CONSEQUENCE OF): | | | | Approximate Interval Between Onset and Death <i>three days</i> | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | b. <i>Pneumonia</i> DUE TO (OR AS A CONSEQUENCE OF): | | | | <i>one day</i> | |
| | | c. <i>anoxic Brain damage</i> DUE TO (OR AS A CONSEQUENCE OF): | | | | <i>eighteen days</i> | |
| | | d. <i>Diabetes mellitus with end stage renal disease</i> | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Hypertension - Peritoneal dialysis dependent</i> <i>Severe peripheral vascular disease</i> | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/> | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| | | 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER <i>SOAS M.D.</i> | | | | 29c. LICENSE NUMBER <i>D46020 / D24769</i> | | 29d. DATE SIGNED (Month, Day, Year) <i>5/26/95</i> | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Syed Ali MD. 506 Idlewild Ave. - Easton, Md. 21601 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) <i>MAY 31 '95</i> | | | | 32. REGISTRAR'S SIGNATURE <i>John Davidson-Randall</i> | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

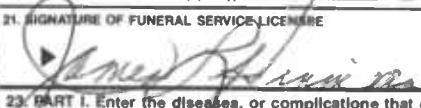

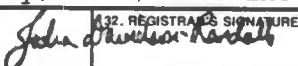
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 21782

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|--|--|---|--|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last) Michael P Cooper | | | | 2. DATE OF DEATH MONTH 07 DAY 07 YEAR 95 | | 3. TIME OF DEATH 0312 M | |
| 4. SOCIAL SECURITY NUMBER 217-92-8682 | | 5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 30 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 07-14-64 | |
| 9a. FACILITY NAME (If not institution, give street and number) PENINSULA REGIONAL MEDICAL CENTER | | | | 9b. CITY, TOWN OR LOCATION OF DEATH SALISBURY | | 9c. COUNTY OF DEATH WICOMICO | |
| RESIDENCE OF DECEDENT | | | | | | | |
| 10a. STATE MARYLAND | | 10b. COUNTY SOMERSET | | 10c. CITY, TOWN OR LOCATION PRINCESS ANNE | | 10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| 10e. STREET AND NUMBER 30198 JOHN SOMERS ROAD | | | | 10f. ZIP CODE 21853 | | 10g. CITIZEN OF WHAT COUNTRY? U.S. | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) College | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) CORRECTIONAL OFFICER | | 16b. KIND OF BUSINESS/INDUSTRY EASTERN CORRECTIONAL INST. | | | |
| 17. FATHER'S NAME (First, Middle, Last) VERNON COOPER | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) JUANITA BOZMAN | | | |
| 19a. INFORMANT'S NAME (Type/Print) JUANITA COOPER | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 30198 JOHN SOMERS ROAD, PRINCESS ANNE, MD. 21853 | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) BEECHWOOD CEMETERY | | DATE 7/10 | | 20c. LOCATION — City or Town, State PRINCESS ANNE, MD. | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE  M00295 | | | | 22. NAME AND ADDRESS OF FACILITY HINMAN FUNERAL HOME PRINCESS ANNE, MD. 21853 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Multiple Trauma DUE TO (OR AS A CONSEQUENCE OF): b. Auto accident DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. | | | | | | | Approximate Interval Between Onset and Death Instant |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | | | | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input checked="" type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 6 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) 07-07-95 | | 28b. TIME OF INJURY 0230 M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| | | 28d. DESCRIBE HOW INJURY OCCURRED Passenger-2 vehicle collision | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) US 13-South | | | |
| | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) Princess Anne, Maryland | | | | | |
| 29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER  D.M.E. | | | | 29c. LICENSE NUMBER D03599 | | 29d. DATE SIGNED (Month, Day, Year) 07-07-95 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (Item 27) (Type, Print) John T. Bulkeley, M.D., 108 Pine Bluff Road, Salisbury, Maryland, 21801 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JUL 11 1995 | | 32. REGISTRAR'S SIGNATURE  | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 21783

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|---|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) Peter Dreyman | | | | 2. DATE OF DEATH MONTH 07 DAY 03 YEAR 1995 | | 3. TIME OF DEATH 7:15 P.M. | |
| 4. SOCIAL SECURITY NUMBER 215-35-1339 | | 5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 90 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 03-16-05 | |
| 9a. FACILITY NAME (If not institution, give street and number) For Chase Rehab and Nursing Center | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Silver Spring | | 9c. COUNTY OF DEATH Montgomery | |
| 10a. STATE Maryland | | 10b. COUNTY Montgomery | | 10c. CITY, TOWN OR LOCATION Takoma Park | | 10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | |
| 10e. STREET AND NUMBER 7620 Maple Avenue | | | | 10f. ZIP CODE 20912 | | 10g. CITIZEN OF WHAT COUNTRY? Ukraine | |
| 11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 4 College (1-4 or 5+) 0 | | 15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Metal Worker | | 15b. KIND OF BUSINESS/INDUSTRY Russian Government | | | |
| 17. FATHER'S NAME (First, Middle, Last) Mehcailovech Dreyman | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Unobtainable | | | |
| 19a. INFORMANT'S NAME (Type/Print) Zhanna Milbert | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7620 Maple Avenue, Takoma Park, Maryland 20912 | | | |
| 20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Fort Lincoln Crematory 7/8 | | 20c. LOCATION — City or Town, State Brentwood, Maryland | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>James J. Phillips</i> | | | | 22. NAME AND ADDRESS OF FACILITY Hines-Rinaldi Funeral Home 11800 New Hampshire Avenue Silver Spring, Maryland 20904 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → adenocarcinoma stomach DUE TO (OR AS A CONSEQUENCE OF): Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): | | | | | | Approximate interval between Onset and Death 4 MO | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input type="checkbox"/> NO | |
| | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA <input checked="" type="checkbox"/> OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| 29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER <i>Walter E. Gooden MD</i> | | | | 29c. LICENSE NUMBER D01120 | | 29d. DATE SIGNED (Month, Day, Year) 3 JULY 1995 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) WALTER E. GOODEN MD 2309 SHOREFIELD RD WHEATON MD | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JUL 07 1995 | | | | 32. REGISTRAR'S SIGNATURE <i>Julia Dawson Randall</i> | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 21784

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) <i>Gulzar Deol</i> | | | | 2. DATE OF DEATH MONTH <i>JULY</i> DAY <i>01</i> YEAR <i>1995</i> | | 3. TIME OF DEATH <i>0340 P M</i> | |
| 4. SOCIAL SECURITY NUMBER <i>218-02-4135</i> | | 5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) <i>85</i> YRS. | | 7. DATE OF BIRTH (Month, Day, Year) <i>April 13, 1910</i> | |
| 8. BIRTHPLACE (State or Foreign Country) <i>India</i> | | | | 9a. FACILITY NAME (If not institution, give street and number) <i>Shady Grove Hospital</i> | | 9b. CITY, TOWN OR LOCATION OF DEATH <i>Rockville</i> | |
| 9c. COUNTY OF DEATH <i>Montgomery</i> | | | | 10a. STATE <i>Maryland</i> | | 10b. COUNTY <i>Montgomery</i> | |
| 10c. CITY, TOWN OR LOCATION <i>Germantown</i> | | | | 10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input type="checkbox"/> NO | | 10e. STREET AND NUMBER <i>18733 White Sands Drive</i> | |
| 10f. ZIP CODE <i>20784</i> | | | | 10g. CITIZEN OF WHAT COUNTRY? <i>India</i> | | 11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: <i>White</i> | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <i>12</i> College (1-4 or 8+) <i>Landlord</i> | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <i>Landlord</i> | | 16b. KIND OF BUSINESS/INDUSTRY <i>Property</i> | |
| 17. FATHER'S NAME (First, Middle, Last) <i>Shiha Singh</i> | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) <i>Unobtainable</i> | | | |
| 19a. INFORMANT'S NAME (Type/Print) <i>Amarjit Deol</i> | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>18733 White Sands Dr. Germantown, Maryland 20784</i> | | | |
| 20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <i>Northern Va. Crematory 7-95</i> | | 20c. LOCATION — City or Town, State <i>Arlington, Va.</i> | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i> | | | | 22. NAME AND ADDRESS OF FACILITY <i>Arlington Funeral Home 3901 N. Fairfax Dr. Arlington Va 22203</i> | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>a. aspiration pneumonia</i> DUE TO (OR AS A CONSEQUENCE OF): Approximate Interval Between Onset and Death <i>19 days</i> Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY <i>M</i> | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | 29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER <i>Anne M.D.</i> | | | | 29c. LICENSE NUMBER <i>D37891</i> | | 29d. DATE SIGNED (Month, Day, Year) <i>July 01 1995</i> | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>A RAJVANSHI M.D. 121 Congressional Ln # 409 Rockville MD 20852</i> | | | | | | | |
| 31. DATE FILED (Month, Day, Year) <i>JUL 07 1995</i> | | | | 32. REGISTRAR'S SIGNATURE <i>John Andrew Randall</i> | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. The first part of the report is devoted to a general survey of the situation in the country. It is followed by a detailed analysis of the economic situation, which shows a steady decline in the standard of living of the population.

2. The second part of the report is devoted to a detailed analysis of the economic situation. It shows a steady decline in the standard of living of the population, which is due to a number of factors, including the lack of investment in the economy and the high level of inflation.

95 21785

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|---|--|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last) Rembrandt H. Dunsmore | | | | 2. DATE OF DEATH MONTH DAY YEAR July 3, 1995 | | 3. TIME OF DEATH 10:30 P M | |
| 4. SOCIAL SECURITY NUMBER 043-26-5235 | | 5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 77 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) June 20, 1918 | |
| 9a. FACILITY NAME (If not institution, give street and number) Manor Care-Potomac | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Potomac | | 9c. COUNTY OF DEATH Montgomery | |
| RESIDENCE OF DECEDENT | | | | | | | |
| 10a. STATE Maryland | | 10b. COUNTY Montgomery | | 10c. CITY, TOWN OR LOCATION Potomac | | 10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 10e. STREET AND NUMBER 10714 Potomac Tennis Lane | | | | 10f. ZIP CODE 20854 | | 10g. CITIZEN OF WHAT COUNTRY? United States | |
| 11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES World War II | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) — College (1-4 or 5+) 5+ | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Neurosurgeon | | 16b. KIND OF BUSINESS/INDUSTRY Medicine | |
| 17. FATHER'S NAME (First, Middle, Last) Rembrandt P. Dunsmore | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Ester Harvey | | | |
| 19a. INFORMANT'S NAME (Type/Print) Keith A. Dunsmore | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11804 Old Gate Place, Rockville, Maryland 20852 | | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Fairview Cemetery July 8, 1995 | | 20c. LOCATION — City or Town, State W. Hartford, Connecticut | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Michael P. Kotta</i> M00348 | | | | 22. NAME AND ADDRESS OF FACILITY Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc., 7557 Wisconsin Ave., Bethesda, MD 20814-3501 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Sepsis DUE TO (OR AS A CONSEQUENCE OF): b. Diabetes DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | | Approximate Interval Between Onset and Death |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Renal Failure | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO | |
| | | 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER <i>Elliot Goldstein</i> | | | | 29c. LICENSE NUMBER D-03518 | | 29d. DATE SIGNED (Month, Day, Year) July 5, 1995 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Elliott Goldstein, M.D., 9410 Old Georgetown Road, Bethesda, Maryland 20814 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JUL 07 1995 | | | | 32. REGISTRAR'S SIGNATURE <i>John D. ...</i> | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 21786

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|--|--|---|--|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last) Roy Winton Dailey | | | | 2. DATE OF DEATH MONTH July DAY 05 YEAR 1995 | | 3. TIME OF DEATH 1130 P M | |
| 4. SOCIAL SECURITY NUMBER 077-05-3634 | | 5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 83 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) Aug. 29, 1911 | |
| 9a. FACILITY NAME (If not institution, give street and number) Shady Grove Adventist Hospital | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Rockville | | 9c. COUNTY OF DEATH Montgomery | |
| 10a. STATE Maryland | | | | 10b. COUNTY Montgomery | | 10c. CITY, TOWN OR LOCATION Rockville | |
| 10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | | | | |
| 10e. STREET AND NUMBER 14521 Melinda Lane | | | | 10f. ZIP CODE 20853 | | 10g. CITIZEN OF WHAT COUNTRY? United States | |
| 11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 12 | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Manager | | 16b. KIND OF BUSINESS/INDUSTRY Corporate | | | |
| 17. FATHER'S NAME (First, Middle, Last) Winton Jerome Dailey | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Nettie Louise Ball | | | |
| 19a. INFORMANT'S NAME (Type/Print) Sally Ann Waldschmidt | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 14521 Melinda Lane, Rockville, Maryland 20853 | | | |
| 20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Specify cemetery, crematory or other place) Montgomery Crematorium, Inc. July 7, 1995 | | 20c. LOCATION — City or Town, State Bethesda, Maryland | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Daile E. Perry M00803 | | | | 22. NAME AND ADDRESS OF FACILITY Robert A. Pumphrey Funeral Home/Rockville, Inc. 300 West Montgomery Avenue, Rockville, Maryland 20850-2805 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Sepsis DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. | | | | | | | Approximate interval Between Onset and Death 1 day |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO | | | | | | | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> 4 Nursing Home <input type="checkbox"/> 5 Residence <input type="checkbox"/> 6 Other (Specify) | | | | | |
| 27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| 29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER Amen de la Cruz MD | | | | 29c. LICENSE NUMBER D38262 | | 29d. DATE SIGNED (Month, Day, Year) July 6, 1995 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) ANURITA MENDHIRATTA 2401 Research Blvd suite 340 ROCKVILLE MD 20854 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JUL 07 1995 | | | | 32. REGISTRAR'S SIGNATURE John A. Davidson-Randall | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

12

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 8 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 21787

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) ADELA S. DAVIS | | | | 2. DATE OF DEATH MONTH JUNE DAY 30 YEAR 1995 | | 3. TIME OF DEATH 11:09A | |
| 4. SOCIAL SECURITY NUMBER 577-07-0976 | | 5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 83 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) Sept. 12, 1911 | |
| 8. BIRTHPLACE (State or Foreign Country) Washington, DC | | | | 9a. FACILITY NAME (If not institution, give street and number) Suburban Hospital | | 9b. CITY, TOWN OR LOCATION OF DEATH Bethesda | |
| 9c. COUNTY OF DEATH Montgomery | | | | 10a. STATE Maryland | | 10b. COUNTY Montgomery | |
| 10c. CITY, TOWN OR LOCATION Bethesda | | | | 10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 10e. STREET AND NUMBER 4743 Bradley Boulevard, #304 | |
| 10f. ZIP CODE 20815 | | | | 10g. CITIZEN OF WHAT COUNTRY? United States | | 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) College | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Secretary | | 16b. KIND OF BUSINESS/INDUSTRY U.S. Government | |
| 17. FATHER'S NAME (First, Middle, Last) James E. Smith | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Milagros Ramirez | | | |
| 19a. INFORMANT'S NAME (Type/Print) Milton G. Davis | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9908 Mayfield Drive Bethesda, Maryland 20817 | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) George Washington Cemetery July 5, 1995 | | 20c. LOCATION — City or Town, State Adelphi, Maryland | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Delmar J. Jento M00202 | | | | 22. NAME AND ADDRESS OF FACILITY Robert A. Pumphrey Funeral Home/ Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue Bethesda, Maryland 20814-3501 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | | | | | | | |
| a. ASPIRATION PNEUMONITIS | | | | | | | |
| DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| b. SMALL BOWEL OBSTRUCTION | | | | | | | |
| DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| c. Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | | |
| d. 12 HRS | | | | | | | |
| 5 DAYS | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | |
| ATRIAL FIBRILLATION | | | | | | | |
| CONGESTIVE HEART FAILURE | | | | | | | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | |
| 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | 28d. DESCRIBE NOW INJURY OCCURRED | | | |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER HAMMETT MD | | | | 29c. LICENSE NUMBER D39966 | | 29d. DATE SIGNED (Month, Day, Year) 6/30/95 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Carolyn A. Hammett, M.D. 6111 Executive Blvd. Rockville, Maryland 20852 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JUL 03 1995 | | | | 32. REGISTRAR'S SIGNATURE John Bruckner-Randall | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 21788

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) Fiorangelo Di Paolo | | | | 2. DATE OF DEATH MONTH June DAY 30 YEAR 95 | | 3. TIME OF DEATH 3:52 P.M. | |
| 4. SOCIAL SECURITY NUMBER 577-50-1201 | | 5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 66 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) Sept. 27, 1928 | |
| 8. BIRTHPLACE (State or Foreign Country) Italy | | 9a. FACILITY NAME (If not institution, give street and number) Holy Cross Hospital | | 9b. CITY, TOWN OR LOCATION OF DEATH Silver Spring | | 9c. COUNTY OF DEATH Montgomery | |
| 10a. STATE Maryland | | 10b. COUNTY Montgomery | | 10c. CITY, TOWN OR LOCATION Wheaton | | 10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 10e. STREET AND NUMBER 2006 Prichard Road | | | | 10f. ZIP CODE 20902 | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 5+ College (1-4 or 5+) 5+ | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Architect | | 16b. KIND OF BUSINESS/INDUSTRY Federal Government | | | |
| 17. FATHER'S NAME (First, Middle, Last) Americo di Paolo | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Antonietta DeGregorio | | | |
| 19a. INFORMANT'S NAME (Type/Print) Grace M. di Paolo | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2006 Prichard Road Wheaton, Maryland 20902 | | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Gate of Heaven Cemetery 7/3/95 | | 20c. LOCATION — City or Town, State Silver Spring, Maryland | | 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | |
| 22. NAME AND ADDRESS OF FACILITY Francis J. Collins Funeral Home, Inc. 500 University Blvd., W. Sil. Spr., MD 20901 | | 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Anteriosclerotic Heart Disease DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input type="checkbox"/> NO | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29a. SIGNATURE AND TITLE OF CERTIFIER | | | | 29c. LICENSE NUMBER DOE546 | | 29d. DATE SIGNED (Month, Day, Year) June 30 95 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) John Tamber 8218 Wisconsin Ave Bethesda Md | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JUL 05 1995 | | | | 32. REGISTRAR'S SIGNATURE | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 21789

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|---|--|--|---|
| 1. DECEDENT'S NAME (First, Middle, Last) Derrick, Oscar J | | | | 2. DATE OF DEATH MONTH 07 DAY 06 YEAR 95 | | 3. TIME OF DEATH 0503A M | |
| 4. SOCIAL SECURITY NUMBER 579-12-3933 | | 5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 71 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) JAN. 24 1924 | |
| 9a. FACILITY NAME (If not institution, give street and number) ANNE ARUNDEL MEDICAL CENTER | | | | 9b. CITY, TOWN OR LOCATION OF DEATH ANNAPOLIS | | 9c. COUNTY OF DEATH COLUMBIA | |
| RESIDENCE OF DECEDENT | | | | | | | |
| 10a. STATE MARYLAND | | 10b. COUNTY ANNE ARUNDEL | | 10c. CITY, TOWN OR LOCATION ANNAPOLIS | | 10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | |
| 10e. STREET AND NUMBER 1257 WASHINGTON DRIVE | | | | 10f. ZIP CODE 21403 | | 10g. CITIZEN OF WHAT COUNTRY? USA | |
| 11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES 1943 - 1946 | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: BLACK | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 11th | | 15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) CLERK/CARPENTER | | 16. KIND OF BUSINESS/INDUSTRY U.S. POSTAL SERVICE | | | |
| 17. FATHER'S NAME (First, Middle, Last) JAMES DERRICK | | | | 16. MOTHER'S NAME (First, Middle, Maiden Surname) LILA TAYLOR | | | |
| 19a. INFORMANT'S NAME (Type/Print) DOLORES S. DERRICK | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1257 WASHINGTON DRIVE ANNAPOLIS, MD. 21403 | | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) MARYLAND VETERAN CEMETERY 7/11/95 | | 20c. LOCATION — City or Town, State CROWNSVILLE, MD. | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Larry H. Reese</i> | | | | 22. NAME AND ADDRESS OF FACILITY REESE & SONS MORTUARY, P.A. 821 WEST ST. ANNAPOLIS, MD. 21401 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | | a. Metastatic Colorectal Carcinoma | | | | | Approximate Interval Between Onset and Death Dec 1992 |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | b. DUE TO (OR AS A CONSEQUENCE OF): | | | | | |
| | | c. DUE TO (OR AS A CONSEQUENCE OF): | | | | | |
| | | d. DUE TO (OR AS A CONSEQUENCE OF): | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Renal cell carcinoma chronic renal failure Prostate carcinoma | | | | | | | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 26. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| 29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER <i>Peter Graze MD</i> | | | | 29c. LICENSE NUMBER 016364 | | 29d. DATE SIGNED (Month, Day, Year) 7/7/95 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) PETER GRAZE 900 BESTGATE RD. ANNAPOLIS, MD. 21401 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JUL 10 1995 <i>J. A. [Signature]</i> | | | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 21790

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | |
|--|--|---|--|---|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) <i>Alice Mae Deason</i> | | | | 2. DATE OF DEATH MONTH <i>July</i> DAY <i>8</i> YEAR <i>1995</i> | | | | 3. TIME OF DEATH <i>3:15</i> M | |
| 4. SOCIAL SECURITY NUMBER <i>217-24-7582</i> | | 5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) <i>62</i> YRS. | | 7. DATE OF BIRTH (Month, Day, Year) <i>Feb 20, 1933</i> | | 8. BIRTHPLACE (State or Foreign Country) <i>Maryland</i> | |
| 9a. FACILITY NAME (If not institution, give street and number) <i>3071 Brinkley Road Apt 102</i> | | | | 9b. CITY, TOWN OR LOCATION OF DEATH <i>Temple Hills</i> | | | | 9c. COUNTY OF DEATH <i>Prince George's</i> | |
| 10a. STATE <i>Maryland</i> | | | | 10b. COUNTY <i>Prince George's</i> | | 10c. CITY, TOWN OR LOCATION <i>Temple Hills</i> | | 10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 10e. STREET AND NUMBER <i>3071 Brinkley Road, Apt 102</i> | | | | 10f. ZIP CODE <i>20748</i> | | 10g. CITIZEN OF WHAT COUNTRY? <i>United States</i> | | | |
| 11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: <i>White</i> | | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <i>12</i> College (1-4 or 5+) <i></i> | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <i>Housewife & Mom</i> | | 16b. KIND OF BUSINESS/INDUSTRY <i>At Home</i> | | | | | |
| 17. FATHER'S NAME (First, Middle, Last) <i>Wilbur L. Ward</i> | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) <i>Sarah King</i> | | | | | |
| 19a. INFORMANT'S NAME (Type/Print) <i>John E. Deason (Husband)</i> | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>3071 Brinkley Rd, Apt 102, Temple Hills, MD</i> | | | | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory, or other place) <i>Maryland Veterans Cem. July 8, 1995</i> | | 20c. LOCATION — City or Town, State <i>Cheltenham, MD</i> | | | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>John E. Deason</i> | | | | 22. NAME AND ADDRESS OF FACILITY <i>Lee Funeral Home, Inc 6633 Old Alexander Ferry Rd, Clinton MD</i> | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Interosseptic cardiovascular disease</i> DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. | | | | | | | | Approximate Interval Between Onset and Death | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M <input type="checkbox"/> 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | |
| | | 28d. DESCRIBE HOW INJURY OCCURRED | | | | 28e. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. SIGNATURE AND TITLE OF CERTIFIER <i>Augusto P. Rodriguez M.D.</i> | | | | 29c. LICENSE NUMBER <i>D21230</i> | | 29d. DATE SIGNED (Month, Day, Year) <i>July 8, 1995</i> | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>Augusto P. Rodriguez, M.D. 5009 Rayburn Ct., Camp Springs, MD 20748</i> | | | | | | | | | |
| 31. DATE FILED (Month, Day, Year) <i>JUL 11 1995</i> | | | | 32. REGISTRAR'S SIGNATURE <i>John A. Hudson-Randall</i> | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 21791

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|---|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) Helen Theall Deason | | | | 2. DATE OF DEATH MONTH DAY YEAR July 7 1995 | | 3. TIME OF DEATH 3:15PM M | |
| 4. SOCIAL SECURITY NUMBER 229-60-0221 | | 5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 8. AGE (In yrs. last birthday) 84 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) July 7, 1911 | |
| 9a. FACILITY NAME (If not institution, give street and number) 207 Main St. | | 9b. CITY, TOWN OR LOCATION OF DEATH New Windsor | | | | 9c. COUNTY OF DEATH Carroll | |
| 10a. STATE Maryland | | 10b. COUNTY Carroll | | 10c. CITY, TOWN OR LOCATION New Windsor | | 10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 10e. STREET AND NUMBER 207 Main St. | | | | 10f. ZIP CODE 21776 | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 | | 15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) preschool director | | 15b. KIND OF BUSINESS/INDUSTRY city government | | | |
| 17. FATHER'S NAME (First, Middle, Last) Earl Worden Chafee | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Edith Theall | | | |
| 19a. INFORMANT'S NAME (Type/Print) Marlene D. Smith | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 207 Main St. New Windsor, MD 21776 | | | |
| 20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) Carroll Cremation, Inc. | | 20c. LOCATION — City or Town, State Hampstead, MD | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Catharine O. Hartzler</i> | | | | 22. NAME AND ADDRESS OF FACILITY D.D. Hartzler & Sons New Windsor, MD | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>leukemic Leukemia</i> DUE TO (OR AS A CONSEQUENCE OF): <i>advanced age</i> Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST c. d. PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>NA</i> | | | | | | Approximate Interval Between Onset and Death <i>1 yr</i> <i>1/2</i> | |
| 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, school, factory, office building, etc. (Specify) <i>NA</i> | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. SIGNATURE AND TITLE OF CERTIFIER <i>John W. Middleton</i> | | 29c. LICENSE NUMBER D25443 | | 29d. DATE SIGNED (Month, Day, Year) 7-7-95 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>John W. Middleton 688 Poole Road Westminster, Md 21157</i> | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JUL 11 1995 | | 32. REGISTRAR'S SIGNATURE <i>John W. Middleton</i> | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 21792

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) ETHEL MAY DIVELBLISS | | | | 2. DATE OF DEATH MONTH JULY DAY 4 YEAR 1995 | | 3. TIME OF DEATH 07:28 A M | |
| 4. SOCIAL SECURITY NUMBER 219-54-1583 | | 5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 68 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) May 24, 1927 | |
| 9a. FACILITY NAME (If not institution, give street and number) SACRED HEART HOSPITAL | | | | 9b. CITY, TOWN OR LOCATION OF DEATH CUMBERLAND | | 9c. COUNTY OF DEATH ALLEGANY | |
| RESIDENCE OF DECEDENT | | | | | | | |
| 10a. STATE MD | | 10b. COUNTY Allegany | | 10c. CITY, TOWN OR LOCATION Cumberland | | 10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | |
| 10e. STREET AND NUMBER 10 Race Street | | | | 10f. ZIP CODE 21502 | | 10g. CITIZEN OF WHAT COUNTRY? USA | |
| 11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No - If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE - American Indian, Black, White, etc. Specify: white | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) College | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Homemaker | | 16b. KIND OF BUSINESS/INDUSTRY Own Home | | | |
| 17. FATHER'S NAME (First, Middle, Last) Robert Munday | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Audrey (Post) | | | |
| 19a. INFORMANT'S NAME (Type/Print) Patricia A. Layton | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 431 South Street; Cumberland, MD 21502 | | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Mt. Herman Cemetery | | DATE 07/07 | | 20c. LOCATION - City or Town, State Cumberland, MD | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>James J. Scarpelli</i> | | | | 22. NAME AND ADDRESS OF FACILITY Scarpelli Funeral Home Cumberland, MD 21502 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | | a. pneumonia | | | | Approximate Interval Between Onset and Death 1 week | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | b. retained secretions | | | | 2 weeks | |
| | | c. prolonged immobility | | | | 3 weeks | |
| | | d. regain of consciousness after sigmoid colectomy | | | | 3 weeks | |
| | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. chronic obstructive pulmonary disease | | | | | | 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/> | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| | | 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. PLACE OF INJURY - At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER <i>Donald Manger MD</i> | | | | 29c. LICENSE NUMBER 1009231 | | 29d. DATE SIGNED (Month, Day, Year) JULY 4 1995 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) DONALD MANGER RT 2 BOX 888 CUMBERLAND MARYLAND 21502 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JUL 07 1995 | | 32. REGISTRAR'S SIGNATURE <i>John Anderson</i> | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

P.O. BOX 68760

DIVISION OF VITAL RECORDS

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 21793

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|---|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) FLORENCE NAOMI DEREMER | | | | 2. DATE OF DEATH MONTH JULY DAY 3 YEAR 1995 | | 3. TIME OF DEATH 01:45 AM | |
| 4. SOCIAL SECURITY NUMBER 215-44-7795 | | 5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 88 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) DEC 21 1906 | |
| 9a. FACILITY NAME (If not institution, give street and number) SACRED HEART HOSPITAL | | | | 9b. CITY, TOWN OR LOCATION OF DEATH CUMBERLAND | | 9c. COUNTY OF DEATH ALLEGANY | |
| 10a. STATE MARYLAND | | 10b. COUNTY ALLEGANY | | 10c. CITY, TOWN OR LOCATION CUMBERLAND | | 10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| 10e. STREET AND NUMBER 10520 MOUNT SAVAGE ROAD | | | | 10f. ZIP CODE 21502 | | 10g. CITIZEN OF WHAT COUNTRY? U S A | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: WHITE | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) UNKNOWN College (14 or 5+) College | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) HOMEMAKER | | 16b. KIND OF BUSINESS/INDUSTRY OWN HOME | | | |
| 17. FATHER'S NAME (First, Middle, Last) FRANK LOUIS MILLER | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) SUSAN MARY PHELIPI | | | |
| 19a. INFORMANT'S NAME (Type/Print) JAMES M. DEREMER | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10520 MT SAVAGE ROAD CUMBERLAND, MD 21502 | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) RESTLAWN MEMORIAL GAR 7/5 | | 20c. LOCATION — City or Town, State LAVALE, MD | | 20d. DATE | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Douglas D. Hafner</i> | | | | 22. NAME AND ADDRESS OF FACILITY HAFFER CHAPEL OF THE HILLS MORTUARY 1302 NATIONAL HWY LAVALE, MD 21502 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Cardiovascular Collapse Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. Sepsis b. Cholangio Carcinoma c. Diabetes II d. Severe to Moderate - Enterofag Severe to Moderate - Enterofag Diabetes II Colon cancer Metastatic Resection Staphylococcus Aureus | | | | | | | Approximate Interval Between Onset and Death 15 minutes 3 weeks 6 months |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Severe to Moderate - Enterofag Diabetes II Colon cancer Metastatic Resection Staphylococcus Aureus | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | | | | 24c. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/> |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Homicide 8 <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| 28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28e. DESCRIBE HOW INJURY OCCURRED | | | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | 28g. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER <i>Felipa M. FACP</i> | | | | 29c. LICENSE NUMBER 013601 | | 29d. DATE SIGNED (Month, Day, Year) July 3, 1995 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) V. RAUL FELIPA 921 Bishop Walsh Rd Cumberland Md | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JUL 05 1995 | | | | 32. REGISTRAR'S SIGNATURE <i>[Signature]</i> | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 21794

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) William Milford Dukes | | | | 2. DATE OF DEATH MONTH DAY YEAR May 29, 1995 | | 3. TIME OF DEATH 2301P M | |
| 4. SOCIAL SECURITY NUMBER 166-05-7073 | | 5. SEX XX M 2 <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 85 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) May 12, 1910 | |
| 8. BIRTHPLACE (State or Foreign Country) MD | | | | 9. FACILITY NAME (If not institution, give street and number) Kent & Queen Anne's Co. Hospital Inc. | | | |
| 10. CITY, TOWN OR LOCATION OF DEATH Chestertown | | | | 11. COUNTY OF DEATH Kent | | | |
| 12a. STATE Maryland | | 12b. COUNTY Kent | | 12c. CITY, TOWN OR LOCATION Worton | | 12d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 13. STREET AND NUMBER 25365 Worton Lynch Road | | | | 14. ZIP CODE 21678 | | 15. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 16. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 17. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 18. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 19. RACE — American Indian, Black, White, etc. Specify: White | |
| 20. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (9-12) 7 College (1-4 or 5+) 0 | | 21. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Bartender | | 22. KIND OF BUSINESS/INDUSTRY Tavern | | | |
| 23. FATHER'S NAME (First, Middle, Last) William Thomas Dukes | | | | 24. MOTHER'S NAME (First, Middle, Maiden Surname) Tina Lucille Chilcutt | | | |
| 25. INFORMANT'S NAME (Type/Print) Hilda Mason Dukes | | | | 26. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 25365 Worton Lynch Rd. Worton, MD 21678 | | | |
| 27. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 28. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Union Cemetery 6/3/95 | | 29. LOCATION — City or Town, State Worton, MD | | | |
| 30. SIGNATURE OF FUNERAL SERVICE LICENSEE Marvin V. Williams Jr. | | | | 31. NAME AND ADDRESS OF FACILITY Marvin V. Williams Jr. Chestertown, MD 21620 | | | |
| 32. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. RUPTURED ABDOMINAL AORTIC ANEURYSM 2 1/2 hrs DUE TO (OR AS A CONSEQUENCE OF): b. PERIPHERAL VASCULAR DISEASE 75 yrs. DUE TO (OR AS A CONSEQUENCE OF): c. _____ DUE TO (OR AS A CONSEQUENCE OF): d. _____ SEQUENTIALLY LIST CONDITIONS, If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | | |
| 33. PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. CHRONIC OBSTRUCTIVE PULMONARY DISEASE ATHEROSCLEROTIC CARDIOVASCULAR DISEASE DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | |
| 34. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 35. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | | |
| 36. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 37. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 38. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Homicide 4 <input type="checkbox"/> Undetermined | | 39. DATE OF INJURY (Month, Day, Year) | | 40. TIME OF INJURY M | | 41. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 42. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 43. DESCRIBE HOW INJURY OCCURRED | | | |
| 44. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | 45. DATE SIGNED (Month, Day, Year) 5-31-95 | | | |
| 46. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 47. SIGNATURE AND TITLE OF CERTIFIER Helen A. Noble MD | | | | 48. LICENSE NUMBER D41587 | | 49. DATE SIGNED (Month, Day, Year) 5-31-95 | |
| 50. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Helen A. Noble Chestertown, MD 21620 | | | | | | | |
| 51. DATE FILED (Month, Day, Year) JUN 02 '95 | | | | 52. REGISTRAR'S SIGNATURE Julia Davidson-Randall | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.


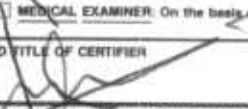
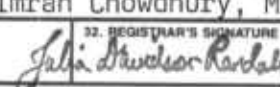
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Amended #1, 7/7/95, J.W. Montgomery Co.

95 21795

1 -
FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | | | |
|---|--|---|--|---|---|---|---|--|---|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) Curtis Emmons Gene Emmons | | | | 2. DATE OF DEATH MONTH July DAY 5 YEAR 1995 | | 3. TIME OF DEATH 11:38 A.M. | | | | | |
| 4. SOCIAL SECURITY NUMBER 446-42-5582 | | 5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F | 6. AGE (In yrs. last birthday) 51 YRS. | IF UNDER 1 YEAR MONTHS 0 DAYS 0 | IF UNDER 24 HRS. HOURS 0 MIN. 0 | 7. DATE OF BIRTH (Month, Day, Year) June 13, 1944 | | 8. BIRTHPLACE (State or Foreign Country) Oklahoma | | | |
| 9a. FACILITY NAME (If not institution, give street and number) Laurel Regional Hospital | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Laurel | | | 9c. COUNTY OF DEATH Prince George's | | | | |
| 10a. STATE Oklahoma | | | | 10b. COUNTY Cleveland | | 10c. CITY, TOWN OR LOCATION Norman | | | 10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | |
| 10e. STREET AND NUMBER 1816 Oak Meadow Drive | | | | 10f. ZIP CODE 73071 | | 10g. CITIZEN OF WHAT COUNTRY? United States | | | | | |
| 11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | | 14. RACE — American Indian, Black, White, etc. Specify: White | | | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 10 College (1-4 or 5+) College | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Dispatcher | | | 16b. KIND OF BUSINESS/INDUSTRY Taxi Service | | | | | | |
| 17. FATHER'S NAME (First, Middle, Last) Paul Dewey Emmons | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Wanda Lee Humphrey | | | | | | | |
| 19a. INFORMANT'S NAME (Type/Print) Patricia Dixon (Sister) | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 517 St. Clair Norman, OK 73069 | | | | | | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Tecumseh Cemetery | | DATE 7-10 | | 20c. LOCATION — City or Town, State Tecumseh, OK | | | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE  M00827 | | | | 22. NAME AND ADDRESS OF FACILITY Rapp Funeral Services, P. A. 933 Gist Avenue, Silver Spring, MD 20910 | | | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → HIV @ AIDS Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST HIV wasting syndrome Cardio respiratory failure Sepsis | | | | | | | | Approximate Interval Between Onset and Death | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 25. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | | | |
| 27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED | | | |
| | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | |
| 29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. SIGNATURE AND TITLE OF CERTIFIER  Imran Chowdhury, M.D. | | | | 29c. LICENSE NUMBER 42019 | | 29d. DATE SIGNED (Month, Day, Year) | | | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Imran Chowdhury, M.D. | | | | 31. DATE FILED (Month, Day, Year) JUL 07 1995 | | | | 32. REGISTRAR'S SIGNATURE  | | | |

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR

95 21796

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|---|--|--|---|
| 1. DECEASED'S NAME (First, Middle, Last) Sister M. Irenita Ecklin | | | | 2. DATE OF DEATH MONTH DAY YEAR June 30 1995 | | 3. TIME OF DEATH 10:00 A M | |
| 4. SOCIAL SECURITY NUMBER 579-66-6684 | | 5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 86 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) Dec. 6, 1908 | |
| 9a. FACILITY NAME (If not institution, give street and number) Saint Angela Hall | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Kensington | | 9c. COUNTY OF DEATH Montgomery | |
| 10a. STATE Maryland | | | | 10b. COUNTY Montgomery | | 10c. CITY, TOWN OR LOCATION Kensington | |
| 10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | | | | |
| 10e. STREET AND NUMBER 5000 Strathmore Avenue | | | | 10f. ZIP CODE 20895 | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 11. MARITAL STATUS 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 5+ | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) College Professor | | 16b. KIND OF BUSINESS/INDUSTRY Art Teacher | | | |
| 17. FATHER'S NAME (First, Middle, Last) Eslie James Ecklin | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Margaret Kaufman | | | |
| 19a. INFORMANT'S NAME (Type/Print) Sr. Mary Jane Honan, C.S.C. | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5000 Strathmore Avenue Kensington, Maryland 20895 | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Gate of Heaven Cemetery 7/3/95 | | 20c. LOCATION — City or Town, State Silver Spring, Maryland | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Chew J. Cole</i> | | | | 22. NAME AND ADDRESS OF FACILITY Francis J. Collins Funeral Home, Inc. 500 University Blvd., W. Sil. Spr., MD 20901 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Congestive Heart Failure DUE TO (OR AS A CONSEQUENCE OF): b. Coronary Artery Disease DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST | | | | | | | Approximate Interval Between Onset and Death |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Hypertension | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | | | | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER <i>Donald L. Bucy</i> | | | | 29c. LICENSE NUMBER D00957 | | 29d. DATE SIGNED (Month, Day, Year) June 30, 1995 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Donald L. Bucy, M.D. 809 Veirs Mill Road, Rockville, MD 20851 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JUL 03 1995 | | REGISTRAR'S SIGNATURE <i>John Andrew Randall</i> | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 21797

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | |
|--|--|--|--|---|--|---|--|--|--|
| 1. DECEASED'S NAME (First, Middle, Last) Frank Embert Jr. | | | | 2. DATE OF DEATH MONTH DAY YEAR May 27, 1995 | | | | 3. TIME OF DEATH 0613 M | |
| 4. SOCIAL SECURITY NUMBER 220-28-2127 | | 5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 63 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) December 24, 1931 | | 8. BIRTHPLACE (State or Foreign Country) Maryland | |
| 9a. FACILITY NAME (If not institution, give street and number) Kent & Queen Anne's County Hospital | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Chestertown | | | | 9c. COUNTY OF DEATH Kent | |
| 10a. STATE Maryland | | | | 10b. COUNTY Kent | | 10c. CITY, TOWN OR LOCATION Millington | | | |
| 10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | | | 10e. STREET AND NUMBER 374 Hurtt Avenue | | 10f. ZIP CODE 21651 | | 10g. CITIZEN OF WHAT COUNTRY? United States | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES Korean Conflict | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: Wh | | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (9-12) 12 College (1-4 or 5+) 12 | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Air Traffic Controller | | 16b. KIND OF BUSINESS/INDUSTRY Aviation | | | |
| 17. FATHER'S NAME (First, Middle, Last) Frank Embert Sr. | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Lola Mae Alexander | | | | | |
| 19a. INFORMANT'S NAME (Type/Print) Mrs. Judy Embert | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 374 Hurtt Avenue - Millington, Maryland 21651 | | | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Ashbury Cemetery - May 31, 1995 | | 20c. LOCATION — City or Town, State Millington, Maryland | | | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE William L. King Jr. | | | | 22. NAME AND ADDRESS OF FACILITY Fellows Funeral Homes, P.A. 370 Cypress Street, Millington, Maryland | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Gastrointestinal Hemorrhage DUE TO (OR AS A CONSEQUENCE OF): b. Thrombocytopenia DUE TO (OR AS A CONSEQUENCE OF): c. Pancreatitis secondary to Metastatic Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | Approximate Interval Between Onset and Death < 1 hr 1 week 1 week | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Coronary Transplantation with Chronic rejection; Chronic Renal Failure DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED | |
| | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | 29b. SIGNATURE AND TITLE OF CERTIFIER George M. Young | | 29c. LICENSE NUMBER D31979 | | 29d. DATE SIGNED (Month, Day, Year) 5-31-95 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) George M. Young MD 100 Brown Street Chestertown, MD 21620 | | | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JUN 01 '95 | | 32. REGISTRAR'S SIGNATURE Julia Davidson-Randall | | | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Louise Everton
FOR
1 - STATE
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | | | |
|---|--|--|--|--|--|---|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) LOUISE SMITH EVERTON | | | | 2. DATE OF DEATH MONTH July DAY 8 YEAR 1995 | | 3. TIME OF DEATH 1:55 A M | | | | | |
| 4. SOCIAL SECURITY NUMBER 420-50-6719 | | 5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F | 6. AGE (In yrs. last birthday) 74 YRS. | IF UNDER 1 YEAR MONTHS 0 DAYS 0 | | IF UNDER 24 HRS. HOURS 0 MIN. 0 | | 7. DATE OF BIRTH (Month, Day, Year) AUG 27 1920 | | 8. BIRTHPLACE (State or Foreign Country) ALABAMA | |
| 9a. FACILITY NAME (If not institution, give street and number) Salisbury Nursing & Rehabilitation | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Salisbury | | | | 9c. COUNTY OF DEATH Wicomico | | | |
| 10a. STATE MARYLAND | | | | 10b. COUNTY SOMERSET | | 10c. CITY, TOWN OR LOCATION PRINCESS ANNE | | | | 10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | |
| 10e. STREET AND NUMBER 227 SOUTH SOMERSET AVENUE | | | | 10f. ZIP CODE 21853 | | | | 10g. CITIZEN OF WHAT COUNTRY? U.S. | | | |
| 11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | | | 14. RACE — American Indian, Black, White, etc. Specify: WHITE | | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 4 | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) ART INSTRUCTOR | | | | 16b. KIND OF BUSINESS/INDUSTRY EDUCATION | | | |
| 17. FATHER'S NAME (First, Middle, Last) AUGUSTUS SMITH | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) LOUISE WOODSON | | | | | | | |
| 19a. INFORMANT'S NAME (Type/Print) ANGUS R. EVERTON | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 315 THORNHILL ROAD, BALTIMORE, MD. 21212 | | | | | | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) ST. EPISCOPALS CEMETERY | | DATE 7/11 | | 20c. LOCATION — City or Town, State PRINCESS ANNE, MD. | | | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | | | | 22. NAME AND ADDRESS OF FACILITY HINMAN FUNERAL HOME PRINCESS ANNE, MD. 21853 | | | | | | | |
| 23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Pneumonia Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST Open heart surgery | | | | Approximate Interval Between Onset and Death Months | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO | | | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | |
| 27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED | | | |
| 28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| 29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER | | | | 29c. LICENSE NUMBER 029349 | | | | 29d. DATE SIGNED (Month, Day, Year) 7/10/95 | | | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) WILLIAM ROBINS, M.D. 1104 HEALTHWAY DR., SALISBURY, MD. | | | | | | | | | | | |
| 31. DATE OF FILING (Month, Day, Year) JUL 11 1995 | | | | 32. SIGNATURE OF REGISTRAR | | | | | | | |

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

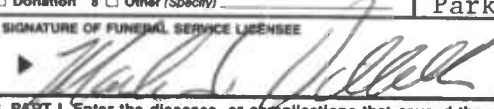
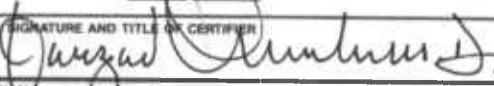

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

95 21799

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) Rebecca Allen Flood | | | | 2. DATE OF DEATH MONTH DAY YEAR July 1, 1995 | | 3. TIME OF DEATH 6:45 AM | |
| 4. SOCIAL SECURITY NUMBER 577-05-8391 | | 5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 79 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) Aug. 19, 1915 | |
| 8. BIRTHPLACE (State or Foreign Country) Virginia | | | | 9a. FACILITY NAME (If not institution, give street and number) Montgomery General Hospital | | 9b. CITY, TOWN OR LOCATION OF DEATH Olney | |
| 9c. COUNTY OF DEATH Montgomery | | | | 10a. STATE Maryland | | 10b. COUNTY Montgomery | |
| 10c. CITY, TOWN OR LOCATION Silver Spring | | | | 10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input type="checkbox"/> NO | | 10e. STREET AND NUMBER 15052 Haslemere Court | |
| 10f. ZIP CODE 20906 | | | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | | 11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 2 College (1-4 or 8+) | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Office Manager | | 16b. KIND OF BUSINESS/INDUSTRY Dental Office | |
| 17. FATHER'S NAME (First, Middle, Last) John Allen | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Rebecca Hogwood | | | |
| 19a. INFORMANT'S NAME (Type/Print) Henry Winston Flood | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 15052 Haslemere Court Silver Spring, Maryland 20906 | | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Parklawn Memorial Park 7/3/95 | | 20c. LOCATION — City or Town, State Rockville, Maryland | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE  | | | | 22. NAME AND ADDRESS OF FACILITY Francis J. Collins Funeral Home, Inc. 500 University Blvd., W. Sil. Spr., MD 20901 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → 1. CARDIOPULMONARY ARREST 2. Severe Hypertension. 3. Chronic Atrial fibrillation with variable Ventricular rate. 4. Acute CVA | | | | | | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Same as above. | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | | | | |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | | | | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | |
| 27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | |
| 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | 28d. DESCRIBE NOW INJURY OCCURRED | | | |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER  (M.D.) | | | | 29c. LICENSE NUMBER D-40201 | | 29d. DATE SIGNED (Month, Day, Year) 7-1-95 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) FARZAD ASSAR, M.D. 1502 S. MAIN ST., MT AIRY, MD 21771 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JUL 03 1995 | | | | 32. REGISTRAR'S SIGNATURE  | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

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95 21800

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|--|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) Margaret Elizabeth Ferris | | | | 2. DATE OF DEATH MONTH DAY YEAR June 28, 1995 | | 3. TIME OF DEATH 3:18 P M | |
| 4. SOCIAL SECURITY NUMBER 220-44-3002 | | 5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 96 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) Dec. 14, 1898 | |
| 8. BIRTHPLACE (State or Foreign Country) Rhode Island | | | | 9a. FACILITY NAME (If not institution, give street and number) Holy Cross Hospital | | 9b. CITY, TOWN OR LOCATION OF DEATH Silver Spring | |
| 9c. COUNTY OF DEATH Montgomery | | | | 10a. STATE Maryland | | 10b. COUNTY Montgomery | |
| 10c. CITY, TOWN OR LOCATION Silver Spring | | | | 10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 10e. STREET AND NUMBER 8505 Springvale Road #157 | |
| 10f. ZIP CODE 20910 | | | | 10g. CITIZEN OF WHAT COUNTRY? USA | | 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 11 College (1-4 or 5+) 11 | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) US Deputy Marshall | | 16b. KIND OF BUSINESS/INDUSTRY US Government | |
| 17. FATHER'S NAME (First, Middle, Last) Patrick James McAuliffe | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Mary Hanna Devitt | | | |
| 19a. INFORMANT'S NAME (Type/Print) William Edward Ferris, III | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12501 Two Farm Drive Silver Spring, Maryland 20904 | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Arlington National Cemetery 7/5/95 | | 20c. LOCATION — City or Town, State Arlington, Virginia | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Steven D. Stroud | | | | 22. NAME AND ADDRESS OF FACILITY Francis J. Collins Funeral Home, Inc. 500 University Blvd. W. Silver Spring, MD 20901 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <u>Acute congestive heart failure</u> DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>Chronic obstructive pulmonary disease</u> | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | |
| 27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER Myron L. Lenken M.D. | | | | 29c. LICENSE NUMBER 006674 | | 29d. DATE SIGNED (Month, Day, Year) 7/30/95 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) MYRON L. LENKEN MD 2309 PHOENIXFIELD RD WILKINSON MD | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JUL 03 1995 | | | | 32. REGISTRAR'S SIGNATURE John Davidson-Randall | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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95 21801

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|--|--|---|--|---|---|
| 1. DECEASED'S NAME (First, Middle, Last) <i>Charles Latimer Fowler</i> | | | | 2. DATE OF DEATH MONTH <i>6</i> DAY <i>29</i> YEAR <i>95</i> | | 3. TIME OF DEATH <i>6:40</i> P.M. | |
| 4. SOCIAL SECURITY NUMBER <i>578-05-5429</i> | | 5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) <i>79</i> YRS. | | 7. DATE OF BIRTH (Month, Day, Year) <i>Oct. 14, 1915</i> | |
| 9a. FACILITY NAME (If not institution, give street and number) <i>Holy Cross Hospital</i> | | | | 9b. CITY, TOWN OR LOCATION OF DEATH <i>Silver Spring</i> | | 9c. COUNTY OF DEATH <i>Montgomery</i> | |
| 10a. STATE <i>Maryland</i> | | | | 10b. COUNTY <i>Montgomery</i> | | 10c. CITY, TOWN OR LOCATION <i>Rockville</i> | |
| 10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | | | | |
| 10e. STREET AND NUMBER <i>14302 Merton Court</i> | | | | 10f. ZIP CODE <i>20853</i> | | 10g. CITIZEN OF WHAT COUNTRY? <i>United States</i> | |
| 11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEASED EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES <i>World War II</i> | | 13. WAS DECEASED OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: <i>White</i> | |
| 15. DECEASED'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <i>12</i> College (1-4 or 5+) <i>-</i> | | 16a. DECEASED'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <i>Loan Guarantee Officer</i> | | 16b. KIND OF BUSINESS/INDUSTRY <i>Veterans Administration</i> | | | |
| 17. FATHER'S NAME (First, Middle, Last) <i>Francis M. Fowler</i> | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) <i>Maude Alice Cooke</i> | | | |
| 19a. INFORMANT'S NAME (Type/Print) <i>Charlene S. Shockley</i> | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>9 N. Brandywine Road, Milford, Delaware 19963</i> | | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <i>Cedar Hill Cemetery July 3, 1995</i> | | 20c. LOCATION — City or Town, State <i>Suitland, Maryland</i> | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Michelle P. Kuttan</i> M00348 | | | | 22. NAME AND ADDRESS OF FACILITY <i>Robert A. Pumphrey Funeral Home/Rockville, Inc., 300 W. Montgomery Ave Rockville, Maryland 20850-2805</i> | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <i>CNS Failure</i> DUE TO (OR AS A CONSEQUENCE OF): b. <i>MULTIPLE CEREBRAL VASCULAR ACCIDENTS</i> DUE TO (OR AS A CONSEQUENCE OF): c. <i>ARTERIO SCLEROTIC CEREBROVASCULAR DISEASE</i> DUE TO (OR AS A CONSEQUENCE OF): d. Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | | Approximate Interval Between Onset and Death <i>1 hr</i> |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | | | | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY <i>M</i> | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| | | 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER <i>Stanley A. Schwartz M.D.</i> | | | | 29c. LICENSE NUMBER <i>17368</i> | | 29d. DATE SIGNED (Month, Day, Year) <i>6/30/95</i> | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>Stanley A. Schwartz, M.D., 2101 Medical Park Drive, #201, Silver Spring, MD 20902</i> | | | | | | | |
| 31. DATE FILED (Month, Day, Year) <i>JUL 03 1995</i> | | 32. REGISTRAR'S SIGNATURE <i>Julia Davidson Rodell</i> | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 21802

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | | |
|--|--|--|--|---|--|--|--|---|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) RICHARD | | | | 2. DATE OF DEATH MONTH JUNE DAY 30 YEAR 1995 | | | | 3. TIME OF DEATH 1:12 A M | | |
| 4. SOCIAL SECURITY NUMBER | | 5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 49 YRS. | | IF UNDER 1 YEAR MONTHS XX DAYS XX | | IF UNDER 24 HRS. HOURS XX MIN. XX | | |
| 7. DATE OF BIRTH (Month, Day, Year) Mar 26 1946 | | | | 8. BIRTHPLACE (State or Foreign Country) New York | | | | | | |
| 9a. FACILITY NAME (If not institution, give street and number) Fallston General Hospital | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Fallston | | | | 9c. COUNTY OF DEATH Harford | | |
| 10a. STATE Maryland | | | | 10b. COUNTY Harford | | 10c. CITY, TOWN OR LOCATION Abingdon | | 10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | |
| 10e. STREET AND NUMBER 3721 Torey Lane | | | | 10f. ZIP CODE 21009 | | 10g. CITIZEN OF WHAT COUNTRY? USA | | | | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | | | 14. RACE — American Indian, Black, White, etc. Specify: Black | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) | | | | 16b. KIND OF BUSINESS/INDUSTRY | | |
| 17. FATHER'S NAME (First, Middle, Last) Wilmot Ferdinand | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Leona Edwards | | | | | | |
| 19a. INFORMANT'S NAME (Type/Print) Linda Shine | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3721 Torey Lane Abingdon, Maryland 21009 | | | | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Bel Air Memorial Gard. 7-6 | | DATE June 30 1995 | | 20c. LOCATION — City or Town, State Bel Air, Maryland | | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | | | | 22. NAME AND ADDRESS OF FACILITY Beard Funeral Home 552 Lewis ST Havre de Grace, MD 21078 | | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Advanced Systemic AIDS DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST Intravenous Drug Use DUE TO (OR AS A CONSEQUENCE OF): Alcoholic cirrhosis DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | Approximate Interval Between Onset and Death 6 months 2 years | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Alcoholic cirrhosis | | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | | | | | | | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 6 <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED | | |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER Salvatore Raiti MD | | | | 29c. LICENSE NUMBER D 12753 | | 29d. DATE SIGNED (Month, Day, Year) June 30 1995 | | | | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) SALVATORE RAITI MD 5805 STONY RUN DRIVE BALTIMORE MD 21210 | | | | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JUL 11 1995 | | | | 32. REGISTRAR'S SIGNATURE | | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION


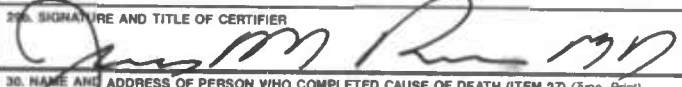
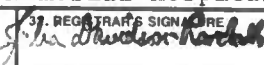
BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 21803

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) FREDERICK H. FLANAGAN | | | | 2. DATE OF DEATH MONTH July DAY 3 YEAR 1995 | | 3. TIME OF DEATH 11:50 p m | |
| 4. SOCIAL SECURITY NUMBER 213-22-4582 | | 5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 68 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) May 24, 1927 | |
| 8. BIRTHPLACE (State or Foreign Country) West Virginia | | | | 9a. FACILITY NAME (If not institution, give street and number) Memorial Hospital | | 9b. CITY, TOWN OR LOCATION OF DEATH Cumberland | |
| 9c. COUNTY OF DEATH Allegany | | | | 10a. STATE WV | | 10b. COUNTY Mineral | |
| 10c. CITY, TOWN OR LOCATION Keyser | | | | 10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 10e. STREET AND NUMBER HC 72, Box 112 | |
| 10f. ZIP CODE 26726 | | | | 10g. CITIZEN OF WHAT COUNTRY? USA | | | |
| 11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES World War II | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 8 | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Welder | | 16b. KIND OF BUSINESS/INDUSTRY Ironworkers Union | |
| 17. FATHER'S NAME (First, Middle, Last) Henry H. Flanagan | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Sarah J. Ketterman | | | |
| 19a. INFORMANT'S NAME (Type/Print) Hilda R. Flanagan | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) HC 72, Box 112 Keyser, WV 26726 | | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) July 7 Maryland State Veteran's Cemetery | | 20c. LOCATION — City or Town, State Rocky Gap Flintstone, Maryland | | 20d. LOCATION — City or Town, State | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE  | | | | 22. NAME AND ADDRESS OF FACILITY Rotruck-Smith Funeral Home 85 S. Main Street Keyser, WV 26726 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | | | | | | | |
| a. Chronic Respiratory Insufficiency | | | | | | | |
| DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| b. Emphysema | | | | | | | |
| DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| c. Chronic Bronchitis | | | | | | | |
| DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| d. | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. CA LUNG | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | | | | |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO | | | | | | | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | 28g. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER  | | | | 29c. LICENSE NUMBER D 18769 | | 29d. DATE SIGNED (Month, Day, Year) JULY 5, 1995 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) James Raver, M.D., Memorial Hospital, Cumberland, Md. 21502 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JUL 06 1995 | | | | 32. REGISTRAR'S SIGNATURE  | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR
STATE
REGISTRAR



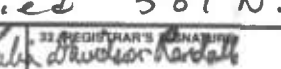
STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH REG. NO.

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

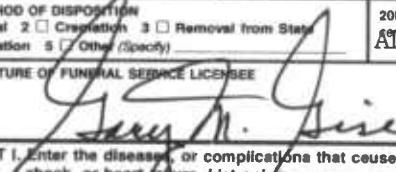
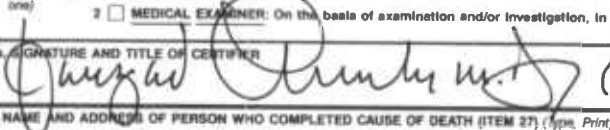
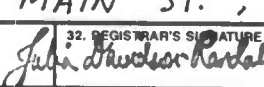
IMPORTANT: If item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| | | | | | | | |
|---|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) CHRISTIAN ALEXANDER GARCIA | | | | 2. DATE OF DEATH MONTH 6 DAY 28 YEAR 1995 | | 3. TIME OF DEATH 3:30 PM | |
| 4. SOCIAL SECURITY NUMBER None | | 5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) YRS. 2 MONTHS 0 DAYS 0 | | 7. DATE OF BIRTH (Month, Day, Year) June 28, 1995 | |
| 8. BIRTHPLACE (State or Foreign Country) Maryland | | | | 9a. CITY, TOWN OR LOCATION OF DEATH Silver Spring | | 9b. COUNTY OF DEATH Montgomery | |
| 10a. STATE Maryland | | | | 10b. COUNTY Montgomery | | 10c. CITY, TOWN OR LOCATION Silver Spring | |
| 10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | 10e. STREET AND NUMBER 15313 Valencia Street | | | |
| 10f. ZIP CODE 20905 | | | | 10g. CITIZEN OF WHAT COUNTRY? United States | | | |
| 11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO Specify: Puerto Rican | | 14. RACE — American Indian, Black, White, etc. Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 0 College (1-4 or 5+) N/A | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) N/A | | 16b. KIND OF BUSINESS/INDUSTRY N/A | | | |
| 17. FATHER'S NAME (First, Middle, Last) Kamal Rao | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Erin Garcia | | | |
| 19a. INFORMANT'S NAME (Type/Print) Erin Garcia (Mother) | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) Same as #10 | | | |
| 20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Chesapeake Crematory | | DATE 7-1 | | 20c. LOCATION — City or Town, State Beltsville, MD | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE  | | 22. NAME AND ADDRESS OF FACILITY Rapp Funeral Services, P.A. 933 Gist Ave, Silver Spring, MD 20910 | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Cardiac arrest Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST { b. Prematurity - 14 weeks c. d. | | | | | | Approximate Interval Between Onset and Death | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | | | | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER  | | | | 29c. LICENSE NUMBER D5399 | | 29d. DATE SIGNED (Month, Day, Year) 6/29/95 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Janet R. Fried 501 N. Frederick Ave Gaithersburg MD 20877 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JUL 07 1995 | | 32. REGISTRAR'S SIGNATURE  | | | | | |

95 21805

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) ROSE GERBER | | | | 2. DATE OF DEATH MONTH JULY DAY 3 , YEAR 1995 | | 3. TIME OF DEATH 4:00 P. M. | |
| 4. SOCIAL SECURITY NUMBER 224-22-1856 | | 5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 98 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) NOV. 18, 1896 | |
| 9a. FACILITY NAME (If not institution, give street and number) MERIDIAN NURSING & REHABILITATION CTR. | | | | 9b. CITY, TOWN OR LOCATION OF DEATH SILVER SPRING | | 9c. COUNTY OF DEATH MONTGOMERY | |
| RESIDENCE OF DECEDENT | | | | | | | |
| 10a. STATE MARYLAND | | 10b. COUNTY MONTGOMERY | | 10c. CITY, TOWN OR LOCATION BETHESDA | | 10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | |
| 10e. STREET AND NUMBER 4960 SENTINEL DRIVE | | | | 10f. ZIP CODE 20816 | | 10g. CITIZEN OF WHAT COUNTRY? UNITED STATES | |
| 11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: WHITE | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (9-12) 12 | | 15a. DECEDEENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) HOMEMAKER | | 16b. KIND OF BUSINESS/INDUSTRY OWN HOME | | | |
| 17. FATHER'S NAME (First, Middle, Last) MAYER DAVID COHEN | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) MIRIAM SLOTT | | | |
| 19a. INFORMANT'S NAME (Type/Print) SYLVAN GERBER (SON) | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4960 SENTINEL DRIVE - BETHESDA, MARYLAND 20816 | | | | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematorium, or other place) ADATH YESHURON CEMETERY | | DATE 7/6 | | 20c. LOCATION — City or Town, State BALTIMORE, MARYLAND | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE  | | | | 22. NAME AND ADDRESS OF FACILITY DANZANSKY-GOLDBERG MEMORIAL CHAPELS, INC. 1170 ROCKVILLE PIKE, ROCKVILLE, MD 20852 | | | |
| 23. PART I. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | | a. 1. S/P Acute GI Bleed 2. Cardiopulmonary Arrest. DUE TO (OR AS A CONSEQUENCE OF): b. 3. Hypertension DUE TO (OR AS A CONSEQUENCE OF): c. 4. Vascular Atherosclerosis DUE TO (OR AS A CONSEQUENCE OF): d. 5. Dementia | | | | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | Approximate Interval Between Onset and Death 11:00 AM to 4:00 PM 7/3/95 15 Hours to 0 minutes | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1. Gastritis | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | | | | |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | | | | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28d. DESCRIBE HOW INJURY OCCURRED | | | |
| 29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER  (M.D.) | | | | 29c. LICENSE NUMBER D40201 | | 29d. DATE SIGNED (Month, Day, Year) 7/4/95 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 1502 S. MAIN ST., MT AIRY, MD 21771 FARZAD ASSAR, M.D. | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JUL 07 1995 | | | | 32. REGISTRAR'S SIGNATURE  | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 21807

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) Charles Newton Graham, Sr. | | | | 2. DATE OF DEATH MONTH DAY YEAR June 30, 1995 | | 3. TIME OF DEATH 1:05 P M | |
| 4. SOCIAL SECURITY NUMBER 059-03-2378 | | 5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 84 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) Feb. 7, 1911 | |
| 8. BIRTHPLACE (State or Foreign Country) New York | | | | 9a. FACILITY NAME (If not institution, give street and number) Montgomery General Hospital | | 9b. CITY, TOWN OR LOCATION OF DEATH Olney | |
| 9c. COUNTY OF DEATH Montgomery | | | | 10a. STATE Maryland | | 10b. COUNTY Montgomery | |
| 10c. CITY, TOWN OR LOCATION Silver Spring | | | | 10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 10e. STREET AND NUMBER 14801 Pennfield Circle #202 | |
| 10f. ZIP CODE 20906 | | | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | | 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | | |
| 14. RACE — American Indian, Black, White, etc. Specify: White | | | | 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 4 | | | |
| 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Public Relations Manager | | | | 16b. KIND OF BUSINESS/INDUSTRY Communications | | | |
| 17. FATHER'S NAME (First, Middle, Last) Robert Graham | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Arlene Williams | | | |
| 19a. INFORMANT'S NAME (Type/Print) Margaret J. Graham | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 14801 Pennfield Circle #202 Silver Spring, Maryland 20906 | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Parklawn Cemetery 7/3/95 | | | |
| 20c. LOCATION — City or Town, State Rockville, Maryland | | | | 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>James E. Dooly</i> | | | |
| 22. NAME AND ADDRESS OF FACILITY Francis J. Collins Funeral Home, Inc. 500 University Blvd., W. Sil. Spr., MD 20901 | | | | 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Respiratory failure</i> Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST { <i>Gastrointestinal hemorrhage</i> <i>Suspected duodenal ulcer</i> PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Insulin dependent diabetes mellitus</i> <i>Accelerated heart disease</i> DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | |
| 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | | | 28a. DATE OF INJURY (Month, Day, Year) 28b. TIME OF INJURY M 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO 28d. DESCRIBE HOW INJURY OCCURRED 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | 29b. SIGNATURE AND TITLE OF CERTIFIER <i>John G. Lodmell MD</i> | | | |
| 29c. LICENSE NUMBER D05809 | | | | 29d. DATE SIGNED (Month, Day, Year) 6/30/95 | | | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) JOHN G. LODMELL MD, 2901 Olney Rd. Olney, MD 20832 | | | | 31. DATE FILED (Month, Day, Year) JUL 03 1995 | | | |
| 32. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i> | | | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 21808

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|---|--|---|--|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last) EDWARD FRANCIS GASKIN, JR. | | | | 2. DATE OF DEATH MONTH DAY YEAR July 9, 1995 | | 3. TIME OF DEATH 1:14 A M | |
| 4. SOCIAL SECURITY NUMBER 218-26-0380 | | 5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 66 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) May 30, 1929 | |
| 8a. FACILITY NAME (If not institution, give street and number) Carroll County General Hospital | | | | 8b. CITY, TOWN OR LOCATION OF DEATH Westminster | | 8c. COUNTY OF DEATH Carroll | |
| 10a. STATE Maryland | | 10b. COUNTY Carroll | | 10c. CITY, TOWN OR LOCATION Westminster | | 10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| 10e. STREET AND NUMBER 1331 Baltimore Blvd. | | | | 10f. ZIP CODE 21157 | | 10g. CITIZEN OF WHAT COUNTRY? United States | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES Korea | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 9 College (1-4 or 5+) 9 | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Paper Cutter | | 16b. KIND OF BUSINESS/INDUSTRY Printing | | | |
| 17. FATHER'S NAME (First, Middle, Last) Edward Francis Gaskin, Sr. | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Mary Elizabeth Gutman | | | |
| 19a. INFORMANT'S NAME (Type/Print) Toni L. Carmine | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1331 Baltimore Blvd, Westminster, MD 21157 | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Pipe Creek Cemetery | | OATE 7/12 | | 20c. LOCATION — City or Town, State Linwood, Maryland | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Swan Lahter Myers</i> | | | | 22. NAME AND ADDRESS OF FACILITY Myers Funeral Home 91 Willis Street, Westminster, MD | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <u>CARDIORESPIRATORY ARREST</u> b. <u>ACUTE MYOCARDIAL INFARCTION</u> c. <u>OLD MYOCARDIAL INFARCTION</u> d. <u>OLD MYOCARDIAL INFARCTION</u> Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | | Approximate interval Between Onset and Death |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>OLD MYOCARDIAL INFARCTION</u> | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | | | | DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/> |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28d. DESCRIBE HOW INJURY OCCURRED | | | | | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. SIGNATURE AND TITLE OF CERTIFIER <i>Bernard Rubin</i> | | 29c. LICENSE NUMBER D22115 | | 29d. DATE SIGNED (Month, Day, Year) 7/11/95 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Dr. Bernard Rubin 8600 Liberty Road, Randallstown, MD 21133 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JUL 11 1995 | | 32. REGISTRAR'S SIGNATURE <i>Julia...</i> | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 21809

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|--|--|--|--|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last) ALCEA M. GIATRAS | | | | 2. DATE OF DEATH MONTH DAY YEAR July 4, 1995 | | 3. TIME OF DEATH 3:33 A M | |
| 4. SOCIAL SECURITY NUMBER 190-30-4446 | | 5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 58 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) Sep 16, 1936 | |
| 8. FACILITY NAME (If not institution, give street and number) Memorial Hospital & Medical Center | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Cumberland | | 9c. COUNTY OF DEATH Allegany | |
| RESIDENCE OF DECEDENT | | | | | | | |
| 10a. STATE MD | | 10b. COUNTY Allegany | | 10c. CITY, TOWN OR LOCATION Cumberland | | 10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | |
| 10e. STREET AND NUMBER 624 Frederick Street | | | | 10f. ZIP CODE 21502 | | 10g. CITIZEN OF WHAT COUNTRY? USA | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: white | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Proprietor | | 16b. KIND OF BUSINESS/INDUSTRY Restaurant | | | |
| 17. FATHER'S NAME (First, Middle, Last) Amedeo D'Ascenzo | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Domenica M. D'Ascenzo | | | |
| 19a. INFORMANT'S NAME (Type/Print) Louis G. Giatras | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 624 Frederick Street; Cumberland, MD 21502 | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) SS Peter Paul Cemetery 07/07 | | 20c. LOCATION — City or Town, State Cumberland, MD | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>James F. Scarpelli</i> | | | | 22. NAME AND ADDRESS OF FACILITY Scarpelli Funeral Home Cumberland, MD 21502 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Cardiorespiratory Arrest DUE TO (OR AS A CONSEQUENCE OF): b. Coronary Artery Disease DUE TO (OR AS A CONSEQUENCE OF): c. Atherosclerosis & Hypertension DUE TO (OR AS A CONSEQUENCE OF): d. Diabetes Mellitus Approximate Interval Between Onset and Death 8 Hours 5 Years 10 Years 5 Years | | | | | | | Approximate Interval Between Onset and Death |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Acute Upper GI Bleeding Cardiogenic Shock | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | | | | 25. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/> |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide 3 <input type="checkbox"/> Homicide 8 <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28e. DESCRIBE HOW INJURY OCCURRED | | | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER <i>W. Hijab</i> | | | | 29c. LICENSE NUMBER D11925 | | 29d. DATE SIGNED (Month, Day, Year) July 4, 1995 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Dr. W. Hijab 909A Seton Drive Cumberland, Md. 21502 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JUL 07 1995 | | | | 32. REGISTRAR'S SIGNATURE <i>John Harrison</i> | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 21810

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | |
|--|--|--|---|---|--|--|---|-----------------------------------|--|
| 1. DECEDENT'S NAME (First, Middle, Last) Mary Elizabeth Gordon | | | | 2. DATE OF DEATH MONTH DAY YEAR July 04 1995 | | | | 3. TIME OF DEATH 2:03 P M | |
| 4. SOCIAL SECURITY NUMBER 218-16-3434 | | 5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | 6. AGE (In yrs. last birthday) 72 YRS. | 7. DATE OF BIRTH (Month, Day, Year) June 12, 1923 | | 8. BIRTHPLACE (State or Foreign Country) Maryland | | | |
| 9a. FACILITY NAME (If not institution, give street and number) Lion's Manor Nursing Home | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Cumberland | | | 9c. COUNTY OF DEATH Allegany | | |
| RESIDENCE OF DECEDENT | | | | | | | | | |
| 10a. STATE Maryland | | 10b. COUNTY Allegany | | 10c. CITY, TOWN OR LOCATION Cumberland | | | 10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | |
| 10e. STREET AND NUMBER 532 Greene Street | | | | 10f. ZIP CODE 21502 | | 10g. CITIZEN OF WHAT COUNTRY? USA | | | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | | 14. RACE — American Indian, Black, White, etc. Specify: Black | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Home Health worker | | | 16b. KIND OF BUSINESS/INDUSTRY Medical | | |
| 17. FATHER'S NAME (First, Middle, Last) Ellsworth Collins | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Helen Massey | | | | | |
| 19a. INFORMANT'S NAME (Type/Print) Alvin E. Harris | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 16122 Misty Lane, S.W. Cumberland, Md. 21502 | | | | | |
| 20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Resthaven Crematory | | 20c. LOCATION — City or Town, State Frederick, Maryland | | | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Ernest A. Riley, Jr. | | | | 22. NAME AND ADDRESS OF FACILITY Leasure-Stein, Inc. 230 Baltimore Avenue Cumberland, Md. 21502 | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Hyperkalemia DUE TO (OR AS A CONSEQUENCE OF): End Stage renal disease DUE TO (OR AS A CONSEQUENCE OF): Diabetes Mellitus DUE TO (OR AS A CONSEQUENCE OF): Approximate Interval Between Onset and Death three days three weeks ten years. | | | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Seizure disorder, Hypertension, CAD, C.H.F. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 28d. DESCRIBE NOW INJURY OCCURRED | |
| | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER V.A. Ranjithan | | | | 29c. LICENSE NUMBER D19750 | | 29d. DATE SIGNED (Month, Day, Year) July 5 1995 | | | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) V.A. Ranjithan, M.D., Lions Manor N.H., Seton Dr., Cumberland, MD. 21502 | | | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JUL 06 1995 | | | | 32. REGISTRAR'S SIGNATURE Davidson-Randall | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 21811

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) MARION FRANCES GORDON | | | | 2. DATE OF DEATH MONTH JUNE DAY 30 YEAR 1995 | | 3. TIME OF DEATH 9:50 A.M. | |
| 4. SOCIAL SECURITY NUMBER 236-36-2013 | | 5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 74 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) Jan. 9 1921 | |
| 9a. FACILITY NAME (If not institution, give street and number) Sacred Heart Hospital | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Cumberland | | 9c. COUNTY OF DEATH Allegany | |
| 10a. STATE West Virginia | | | | 10b. COUNTY Mineral | | 10c. CITY, TOWN OR LOCATION Keyser | |
| 10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | | | | |
| 10e. STREET AND NUMBER Rt. 50, HC 84 Box 84 | | | | 10f. ZIP CODE 26726 | | 10g. CITIZEN OF WHAT COUNTRY? US | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) Unknown College (1-4 or 5+) | | 15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Homemaker | | 15b. KIND OF BUSINESS/INDUSTRY Home | | | |
| 17. FATHER'S NAME (First, Middle, Last) Harry Isaac Norris | | | | 16. MOTHER'S NAME (First, Middle, Maiden Surname) Bessie Maude Middleton | | | |
| 19a. INFORMANT'S NAME (Type/Print) Joycellen Reed | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) HC 84 Box 84, Keyser, WV. 26726 | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Biertown Cemetery 7-2-95 | | 20c. LOCATION — City or Town, State Rawlings, Md. | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Wynne Boal</i> | | | | 22. NAME AND ADDRESS OF FACILITY Boal Funeral Service 111 Church St. Westernport, Md. 21562 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Cardiac arrest Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST Congestive heart failure, decompensated 5 days pulmonary edema 2 days Aspirational pneumonia 2 days PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Septicemia 7 days Pneumonia, cerebrovascular accident DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/> | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DDA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i> | | 29c. LICENSE NUMBER D15463 | | 29d. DATE SIGNED (Month, Day, Year) JUNE 30, 1995 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Shin Kim, 90 main Street Westernport, MD 21562 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JUL 05 1995 | | 32. REGISTRAR'S SIGNATURE <i>[Signature]</i> | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| FOR 1. STATE REGISTRAR | | STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | REG. NO. | |
|---|--|---|--|--|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) Catherine E. Grothe | | | | 2. DATE OF DEATH MONTH July DAY 13, YEAR 1995 | | 3. TIME OF DEATH P | |
| 4. SOCIAL SECURITY NUMBER 203-10-6843 | | 5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 72 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) Sept. 22, 1922 Maryland | |
| 9a. FACILITY NAME (If not institution, give street and number) 21507 York Road | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Maryland Line | | 9c. COUNTY OF DEATH Baltimore | |
| 10a. STATE Maryland | | | | 10b. COUNTY Baltimore | | 10c. CITY, TOWN OR LOCATION Maryland Line | |
| 10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | | | | |
| 10e. STREET AND NUMBER 21507 York Road | | | | 10f. ZIP CODE 21105 | | 10g. CITIZEN OF WHAT COUNTRY? USA | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (9-12) 8 College (1-4 or 5+) | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Post Mistress | | 16b. KIND OF BUSINESS/INDUSTRY U.S. Postal Service | | | |
| 17. FATHER'S NAME (First, Middle, Last) Chester Barben | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Sophia Thomas | | | |
| 19a. INFORMANT'S NAME (Type/Print) Brenda L. Taylor | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21507 York Rd., Maryland Line, Md. 21105 | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Mt. Zion Cemetery 7/17/95 | | 20c. LOCATION — City or Town, State Freeland, Md | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i> | | | | 22. NAME AND ADDRESS OF FACILITY J.J. Hartenstein Mortuary 24 Second St., New Freedom, Pa. 17349 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Atherosclerotic Cardio Renal Vascular Disease</i> DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. | | | | | | Approximate Interval Between Onset and Death | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> OOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| 29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i> | | | | 29c. LICENSE NUMBER 09383 | | 29d. DATE SIGNED (Month, Day, Year) 7/14/95 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>Charles F. O'Donnell MD</i> 408 North House 21210 111 Hamlet Hill Rd Baltimore Md | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JUL 19 1995 | | | | | | | |
| 32. REGISTRAR'S SIGNATURE <i>[Signature]</i> | | | | | | | |

95 21813

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) Mary Catherine Hill | | | | 2. DATE OF DEATH MONTH DAY YEAR July 5, 1995 | | 3. TIME OF DEATH 10:45 P M | |
| 4. SOCIAL SECURITY NUMBER 214-80-8150 | | 5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 61 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) Oct 8, 1934 | |
| 9a. FACILITY NAME (If not institution, give street and number) Montgomery General Hospital | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Olney | | 9c. COUNTY OF DEATH Montgomery | |
| RESIDENCE OF DECEDENT | | | | | | | |
| 10a. STATE Maryland | | 10b. COUNTY Montgomery | | 10c. CITY, TOWN OR LOCATION Silver Spring | | 10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | |
| 10e. STREET AND NUMBER 1164 Good Hope Rd, | | | | 10f. ZIP CODE 20904 | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No - If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE - American Indian, Black, White, etc. Specify: Black | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (8-12) 10th Grade | | 15b. COUNTY (1-4 or 5 +) College | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Housewife | | 16b. KIND OF BUSINESS/INDUSTRY None | |
| 17. FATHER'S NAME (First, Middle, Last) Ralph Dorsey | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Ida Mae Powell | | | |
| 19a. INFORMANT'S NAME (Type/Print) (Daughter) Mrs Joyce Gaither | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1186 Good Hope Rd, Silver Spring, Md 20904 | | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Ash Memorial Cemetery 7/10 | | 20c. LOCATION - City or Town, State Sandy Spring, Md | | 20d. DATE 7/10 | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>George R. Aronson</i> | | | | 22. NAME AND ADDRESS OF FACILITY Snowden Funeral Home P.A. 20850 246 N. Washington St. Rockville, Md | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | | a. Acute Obstruction trachea | | | | | |
| | | b. Laryngectomy + Permanent Tracheostomy | | | | | |
| | | c. Laryngeal Cancer | | | | | |
| | | d. | | | | | |
| Approximate Interval Between Onset and Death | | 1 hour | | | | | |
| 10 years | | 10 years | | | | | |
| 10 years | | 10 years | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Asthma Diabetes mellitus | | | | | | | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| | | 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. PLACE OF INJURY - At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i> MD. | | | | 29c. LICENSE NUMBER D14057 | | 29d. DATE SIGNED (Month, Day, Year) July 6, 1995 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Lewis Keller, MD. 4000 Olney Laytonsville Rd. Olney, Md. 20832 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JUL 07 1995 | | | | 32. REGISTRAR'S SIGNATURE <i>[Signature]</i> | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760


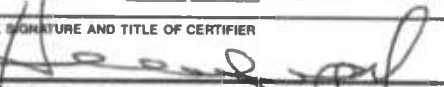

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 21814

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | | | | | | | |
|--|--|--|--|--|--|--|--|---|--|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) Maria Hubert | | | | 2. DATE OF DEATH MONTH DAY YEAR July 3 1995 | | | | 3. TIME OF DEATH 12:27 AM | | | | | | | |
| 4. SOCIAL SECURITY NUMBER 073-34-4674 | | | | 5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 88 YRS. | | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS. HOURS MIN. | | 7. DATE OF BIRTH (Month, Day, Year) July 22, 1906 | | 8. BIRTHPLACE (State or Foreign Country) Germany | |
| 9a. FACILITY NAME (If not institution, give street and number) Montgomery General Hospital | | | | | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Olney | | | | 9c. COUNTY OF DEATH Montgomery | | | |
| RESIDENCE OF DECEDENT | | | | | | | | | | | | | | | |
| 10a. STATE Maryland | | | | 10b. COUNTY Montgomery | | | | 10c. CITY, TOWN OR LOCATION Silver Spring | | | | 10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | |
| 10e. STREET AND NUMBER 15312 Aylesbury Street | | | | | | | | 10f. ZIP CODE 20905 | | | | 10g. CITIZEN OF WHAT COUNTRY? USA | | | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | | | 14. RACE — American Indian, Black, White, etc. Specify: White | | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 0 | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Homemaker | | | | 16b. KIND OF BUSINESS/INDUSTRY Own Home | | | | | | | |
| 17. FATHER'S NAME (First, Middle, Last) Johann Vogel | | | | | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Maria Amersbach | | | | | | | |
| 19a. INFORMANT'S NAME (Type/Print) Ute Andreotti | | | | | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 15312 Aylesbury Street, Silver Spring, Maryland 20905 | | | | | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Gate of Heaven Cemetery 7/7 | | | | 20c. LOCATION — City or Town, State Silver Spring, Maryland | | | | | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE  | | | | | | | | 22. NAME AND ADDRESS OF FACILITY Hines-Rinaldi Funeral Home 11800 New Hampshire Avenue Silver Spring, Maryland 20904 | | | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Acute Myocardial Infarction Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. Arteriosclerosis Heart Disease c. d. Approximate Interval Between Onset and Death Hours Years | | | | | | | | | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | | | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | | | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | | | 28a. DATE OF INJURY (Month, Day, Year) | | | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED | | | |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER  MD | | | | | | | | 29c. LICENSE NUMBER D 25808 | | | | 29d. DATE SIGNED (Month, Day, Year) 7/3/95 | | | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 10513 Georgia Ave Silver Spring Md 20902 | | | | | | | | | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JUL 07 1995 | | | | | | | | 32. REGISTRAR'S SIGNATURE  | | | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

P.O. BOX 68760

DIVISION OF VITAL RECORDS

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 21815

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|---|--|--|--|
| 1. DECEASED'S NAME (First, Middle, Last) CAROTHA CYNTHIA HENRY | | | | 2. DATE OF DEATH MONTH DAY YEAR June 30 1995 | | 3. TIME OF DEATH 0419 AM | |
| 4. SOCIAL SECURITY NUMBER 099-42-6072 | | 5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 64 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) March 17, 1931 | |
| 8. FACILITY NAME (If not institution, give street and number) Shady Grove Adventist Hospital | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Rockville | | 9c. COUNTY OF DEATH Montgomery | |
| 10a. STATE Maryland | | | | 10b. COUNTY Montgomery | | 10c. CITY, TOWN OR LOCATION Germantown | |
| 10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | | | | |
| 10e. STREET AND NUMBER 10 Cottage Field Court | | | | 10f. ZIP CODE 20874 | | 10g. CITIZEN OF WHAT COUNTRY? United States | |
| 11. MARITAL STATUS 1 <input checked="" type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: Black | |
| 15. DECEASED'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (9-12) 12 College (1-4 or 8+) | | 16a. DECEASED'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Dietician | | 16b. KIND OF BUSINESS/INDUSTRY Hospital | | | |
| 17. FATHER'S NAME (First, Middle, Last) Euel Blake | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Geraldine Henderson | | | |
| 19a. INFORMANT'S NAME (Type/Print) Hector G. Henry | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10 Cottage Field Court, Germantown, MD. 20874 | | | |
| 20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Metropolitan Crematory | | DATE 7/4 | | 20c. LOCATION — City or Town, State Alexandria, Virginia | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Michael D. Gilman</i> | | | | 22. NAME AND ADDRESS OF FACILITY DeVol Funeral Home 10E. Deer Park Dr., Gaithersburg, MD. 20877 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | | a. Respiratory Arrest DUE TO (OR AS A CONSEQUENCE OF): | | | | | |
| | | b. Anoxic Encephalopathy DUE TO (OR AS A CONSEQUENCE OF): | | | | | |
| | | c. DUE TO (OR AS A CONSEQUENCE OF): | | | | | |
| | | d. DUE TO (OR AS A CONSEQUENCE OF): | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | | | | |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | | | | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| | | 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER <i>G. Gupta MD</i> | | | | 29c. LICENSE NUMBER 046398 | | 29d. DATE SIGNED (Month, Day, Year) June 30, 1995 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Ghanshyam Gupta, MD 121 Congressional Lane, # 409 Rockville MD 20852 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JUL 06 1995 | | | | 32. REGISTRAR'S SIGNATURE <i>Julia Davidson Randall</i> | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 21816

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|---|---|--------------------------------|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) Rosa Mae Howe | | | | 2. DATE OF DEATH MONTH DAY YEAR June 30 1995 | | 3. TIME OF DEATH 1:13 P M | |
| 4. SOCIAL SECURITY NUMBER 434-12-0877 | | 5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | 6. AGE (In yrs. last birthday) 77 YRS. | IF UNDER 1 YEAR MONTHS DAYS | IF UNDER 24 HRS. HOURS MIN. | 7. DATE OF BIRTH (Month, Day, Year) April 1, 1918 | |
| 9a. FACILITY NAME (If not institution, give street and number) Holy Cross Hospital | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Silver Spring | | 9c. COUNTY OF DEATH Montgomery | |
| RESIDENCE OF DECEDENT | | | | | | | |
| 10a. STATE Maryland | | 10b. COUNTY Montgomery | | 10c. CITY, TOWN OR LOCATION Silver Spring | | 10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 10e. STREET AND NUMBER 8715 First Avenue Apt. #732 | | | | 10f. ZIP CODE 20910 | | 10g. CITIZEN OF WHAT COUNTRY? USA | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) College (1-4 or 5+) | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Travel Agent | | 16b. KIND OF BUSINESS/INDUSTRY Travel | | | |
| 17. FATHER'S NAME (First, Middle, Last) Allynn Achee | | | | 16. MOTHER'S NAME (First, Middle, Maiden Surname) Lucretia Edrington | | | |
| 19a. INFORMANT'S NAME (Type/Print) Clarence W. Howe III | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 826 Loxford Terrace, Silver Spring, MD 20901 | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Gate of Heaven Cemetery 7/5/95 | | OATE | | 20c. LOCATION — City or Town, State Silver Spring, MD | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Steven J. Stroud | | | | 22. NAME AND ADDRESS OF FACILITY Francis J. Collins Funeral Home, Inc. 500 University Blvd. W. Silver Spring, MD 20901 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | | Congestive Heart Failure | | | | Approximate Interval Between Onset and Death 2 days | |
| | | Coronary Artery Disease | | | | 8 yrs. | |
| | | Sepsis / Staphylococcal Bacteremia | | | | 8 days | |
| | | Carcinoma of the Colon (Cecum) | | | | 34 days | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Cardiomyopathy | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28d. DESCRIBE HOW INJURY OCCURRED | | | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER Frank Lewis | | | | 29c. LICENSE NUMBER D43199 | | 29d. DATE SIGNED (Month, Day, Year) 7/1/95 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) FRANK LEWIS, MD, 10301 GEORGIA AVE. #205 SILVER SPRING, MD 20902 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JUL 05 1995 | | 32. REGISTRAR'S SIGNATURE Julia Anderson Randall | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95-3733-031

blh
FOR
STATE
REGISTRARITEMS: 23 PART I, II, 27, 28a-f, PER MEO FILM G-725 7/31/95
STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

95 21817

REG. NO.

| | | | | | | | |
|--|--|--|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) Nhut Huynh | | | | 2. DATE OF DEATH MONTH DAY YEAR June 26 1995 | | 3. TIME OF DEATH 2242 M | |
| 4. SOCIAL SECURITY NUMBER 531-96-5795 | | 5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 74 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) DEC. 17, 1920 | |
| 8. BIRTHPLACE (State or Foreign Country) CAMBODIA | | | | 9a. FACILITY NAME (If not institution, give street and number) Washington Adventist Hospital | | 9b. CITY, TOWN OR LOCATION OF DEATH Takoma Park | |
| 9c. COUNTY OF DEATH Montgomery | | | | 10a. STATE MD. | | 10b. COUNTY MONTGOMERY | |
| 10c. CITY, TOWN OR LOCATION SILVER SPRING | | | | 10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 10e. STREET AND NUMBER 2204 VICTOR CT. | |
| 10f. ZIP CODE 20906 | | | | 10g. CITIZEN OF WHAT COUNTRY? VIETNAM | | 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced | |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: ASIAN | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (9-12) 12 College (1-4 or 5+) 12 | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) SECRETARY | | 16b. KIND OF BUSINESS/INDUSTRY VIETNAMESE GOV'T. | |
| 17. FATHER'S NAME (First, Middle, Last) TUY HUYNH | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) MANH NGUYEN | | | |
| 19a. INFORMANT'S NAME (Type/Print) SUZANNE TRAN | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 300 NORTHWEST 110th ST., SEATTLE, WASHINGTON 98177 | | | |
| 20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) CHAMBERS CREMATORY 6/29 | | 20c. LOCATION — City or Town, State RIVERDALE, MD. | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>W.W. Chambers</i> MO0091 | | | | 22. NAME AND ADDRESS OF FACILITY W. W. CHAMBERS CO., RIVERDALE, MD. 20737 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. ACUTE SALICYLATE INTOXICATION DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| b. DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| c. DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| d. DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ATHEROSCLEROTIC CARDIOVASCULAR DISEASE | | | | | | | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | |
| 27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 2 <input checked="" type="checkbox"/> Pending Investigation 3 <input type="checkbox"/> Accident 4 <input checked="" type="checkbox"/> Suicide 5 <input type="checkbox"/> Could not be determined 6 <input type="checkbox"/> Homicide | | | | 28a. DATE OF INJURY (Month, Day, Year) FOUND 6-26-95 | | 28b. TIME OF INJURY UNKNOWN | |
| 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | 28d. DESCRIBE HOW INJURY OCCURRED SUBJECT USED DRUGS | | | |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) FOUND AT HOME | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) 2007 17th AVENUE HYATTSVILLE, MARYLAND | | | |
| 29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER <i>Dennis J. Chute</i> | | | | 29c. LICENSE NUMBER O.C.M.E. | | 29d. DATE SIGNED (Month, Day, Year) June 27 1995 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) DENNIS J. CHUTE M.D. 111 Penn Street, Baltimore, Maryland 21201 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JUL 03 1995 | | | | 32. REGISTRAR'S SIGNATURE <i>Julia Swanson-Randall</i> | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 29 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 21818

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) William A. Hiener | | | | 2. DATE OF DEATH MONTH DAY YEAR June 30, 1995 | | 3. TIME OF DEATH 10:15 AM M | |
| 4. SOCIAL SECURITY NUMBER 187-20-5194 | | 5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 8. AGE (In yrs. last birthday) 94 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) May 14, 1901 | |
| 9a. FACILITY NAME (If not institution, give street and number) Manor Care-Potomac | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Potomac | | 9c. COUNTY OF DEATH Montgomery | |
| RESIDENCE OF DECEDENT | | | | | | | |
| 10a. STATE Maryland | | 10b. COUNTY Montgomery | | 10c. CITY, TOWN OR LOCATION Rockville | | 10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| 10e. STREET AND NUMBER 12445 St. James Road | | | | 10f. ZIP CODE 20850 | | 10g. CITIZEN OF WHAT COUNTRY? United States | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Electrical Maintenance Inspector | | 16b. KIND OF BUSINESS/INDUSTRY Department of the Army | | | |
| 17. FATHER'S NAME (First, Middle, Last) Joseph Hiener | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Annie Strauss | | | |
| 19a. INFORMANT'S NAME (Type/Print) Eugene H. Hiener | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12445 St. James Road, Rockville, Maryland 20850 | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) St. Wendelins Cemetery July 3, 1995 | | 20c. LOCATION — City or Town, State Pittsburgh, Pennsylvania | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Theresa P. Kutta</i> M00348 | | | | 22. NAME AND ADDRESS OF FACILITY Robert A. Pumphrey Funeral Home/Rockville, Inc., 300 W. Montgomery Ave Rockville, Maryland 20850-2805 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Atherosclerotic Cardiovascular Disease DUE TO (OR AS A CONSEQUENCE OF): Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST { b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. | | | | | | | Approximate Interval Between Onset and Death |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Chronic Renal Insufficiency, Osteoarthritis Hypertension DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28d. DESCRIBE NOW INJURY OCCURRED | | | | | |
| 28e. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER <i>Michael J. Grady</i> | | | | 29c. LICENSE NUMBER D38781 | | 29d. DATE SIGNED (Month, Day, Year) 6/30/95 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Michael J. Grady, M.D., 4910 Massachusetts Ave., N.W., Washington, DC 20016 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JUL 03 1995 | | | | 32. REGISTRAR'S SIGNATURE <i>John Anderson-Randall</i> | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 21819

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|--|--|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last) ANNA B. HOOKER (Anna B. Hooker) | | | | 2. DATE OF DEATH MONTH JULY DAY 8 YEAR 1995 | | 3. TIME OF DEATH 1:15 A M | |
| 4. SOCIAL SECURITY NUMBER 579-09-5595 | | 5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F | 6. AGE (In yrs. last birthday) 93 YRS. | 7. DATE OF BIRTH (Month, Day, Year) Sept 6, 1901 | 8. BIRTHPLACE (State or Foreign Country) Pennsylvania | | |
| 9a. FACILITY NAME (If not institution, give street and number) Southern Maryland Hospital | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Clinton | | 9c. COUNTY OF DEATH Prince George's | |
| 10a. STATE Maryland | | 10b. COUNTY Prince George's | | 10c. CITY, TOWN OR LOCATION Clinton | | 10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 10e. STREET AND NUMBER 10109 White Ave | | | | 10f. ZIP CODE 20735 | | 10g. CITIZEN OF WHAT COUNTRY? United States | |
| 11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 8th College (1-4 or 5+) | | 15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Mail Clerk | | 15b. KIND OF BUSINESS/INDUSTRY Printing Company | | | |
| 17. FATHER'S NAME (First, Middle, Last) Andrew Haber | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Catherine Klinger | | | |
| 19a. INFORMANT'S NAME (Type/Print) Catherine Sherbert | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10109 White Ave., Clinton, Md 20735 | | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Mount Olivet Cemetery | | 20c. LOCATION — City or Town, State Washington DC | | 20d. DATE OF DISPOSITION July 11, 1995 | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | | | | 22. NAME AND ADDRESS OF FACILITY Lee Funeral Home, Inc 5633 Old Alexander Ferry Rd, Clinton | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → UPPER RESPIRATORY INFECTION DUE TO (OR AS A CONSEQUENCE OF): CORONARY ARTERY DISEASE CARDIAC ARRHYTHMIA Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST BREAST CANCER HISTORY | | | | | | | Approximate Interval Between Onset and Death 4 days 2 YEARS 2 WEEKS |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. BREAST CANCER HISTORY | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | | | | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28e. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER Vincent Chen, MD | | | | 29c. LICENSE NUMBER D38129 | | 29d. DATE SIGNED (Month, Day, Year) JUL 8, 1995 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) VINCENT CHEN, 9131 PISCATAWAY RD. #600, CLINTON, MD 20735 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JUL 11 1995 | | | | 32. REGISTRAR'S SIGNATURE John A. Wheeler-Randall | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 21820

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

| | | | | | | | |
|---|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) NELLIE FRANCES HADLEY | | | | 2. DATE OF DEATH MONTH JULY DAY 05 YEAR 1995 | | 3. TIME OF DEATH 3:15 P M | |
| 4. SOCIAL SECURITY NUMBER 219-10-1109 | | 5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 68 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) Sep 14, 1926 | |
| 8a. FACILITY NAME (If not institution, give street and number) THE JOHNS HOPKINS HOSPITAL | | | | 8b. CITY, TOWN OR LOCATION OF DEATH BALITMORE CITY | | 8c. COUNTY OF DEATH BALTIMORE | |
| 9a. RESIDENCE OF DECEDENT | | | | 9b. CITY, TOWN OR LOCATION OF DEATH | | | |
| 10a. STATE MD | | 10b. COUNTY Allegany | | 10c. CITY, TOWN OR LOCATION Cumberland | | 10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | |
| 10e. STREET AND NUMBER 12914 N Cresap Street SW | | | | 10f. ZIP CODE 21502 | | 10g. CITIZEN OF WHAT COUNTRY? USA | |
| 11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: white | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 4 | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired.) Ret. Practical Nurse | | 16b. KIND OF BUSINESS/INDUSTRY Hospital | | | |
| 17. FATHER'S NAME (First, Middle, Last) Charles W. Sisk | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Mary (Smith) | | | |
| 19a. INFORMANT'S NAME (Type/Print) Edward Hadley Patrick Hadley | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12914 N Cresap Street SW Cumberland, MD 21502 P.O. Box 939 Manchester, MD 21102 | | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Rocky Gap Veterans Cem 07/10 | | 20c. LOCATION — City or Town, State Cumberland, MD | | 20d. DATE 07/10 | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Nicholas J. Scarpelli</i> | | | | 22. NAME AND ADDRESS OF FACILITY Scarpelli Funeral Home Cumberland, MD 21502 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. CYSTIC NEOPLASM OF PANCREAS DUE TO (OR AS A CONSEQUENCE OF): b. PNEUMONIA DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): Approximate Interval Between Onset and Death 1 DAY 6 WEEKS | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DIABETES, HYPOTHYROIDISM | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/> | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER <i>Scarpelli, M.D.</i> | | | | 29c. LICENSE NUMBER 045433 | | 29d. DATE SIGNED (Month, Day, Year) JULY 5, 1995 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) ATTILA NAKKEIS, MD JOHNS HOPKINS HOSPITAL 600 N. WOLFE BALTIMORE, MD 21287 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JUL 07 1995 | | | | 32. REGISTRAR'S SIGNATURE <i>John Carroll</i> | | | |

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 21821

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|---|--|--|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) LESTER WARFIELD HARVEY | | | | 2. DATE OF DEATH MONTH DAY YEAR JULY 5 1995 | | 3. TIME OF DEATH 18:30 P M | |
| 4. SOCIAL SECURITY NUMBER 217-10-7088 | | 5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 79 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) Jun 26, 1916 | |
| 8. BIRTHPLACE (State or Foreign Country) WV | | | | 9a. FACILITY NAME (If not institution, give street and number) MEMORIAL HOSPITAL | | 9b. CITY, TOWN OR LOCATION OF DEATH CUMBERLAND | |
| 9c. COUNTY OF DEATH ALLEGANY | | | | 10a. STATE MD | | 10b. COUNTY Allegany | |
| 10c. CITY, TOWN OR LOCATION Cumberland | | | | 10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | 10e. STREET AND NUMBER 229 Baltimore Avenue | |
| 10f. ZIP CODE 21502 | | | | 10g. CITIZEN OF WHAT COUNTRY? USA | | | |
| 11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: white | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) Retired Bartender | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Bar | | 16b. KIND OF BUSINESS/INDUSTRY Bar | | | |
| 17. FATHER'S NAME (First, Middle, Last) William F. Harvey, Sr. | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Abbie (Twigg) | | | |
| 19a. INFORMANT'S NAME (Type/Print) Lila R. Disney | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 305 Third Avenue; Baltimore, MD 21227 | | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) St. Patrick's Cemetery 07/08 | | 20c. LOCATION — City or Town, State Cumberland, MD | | 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Nicholas Scarpelli | |
| 22. NAME AND ADDRESS OF FACILITY Scarpelli Funeral Home Cumberland, MD 21502 | | 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Chronic Obstructive Pulmonary Disease DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): Approximate Interval Between Onset and Death 10 years | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURED | | | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | 29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER Dr. Sunil Gupta | | | | 29c. LICENSE NUMBER D 33280 | | 29d. DATE SIGNED (Month, Day, Year) JULY 6, 1995 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) DR. SUNIL GUPTA, JOHNSON HEIGHTS MEDICAL BLDG., CUMBERLAND, MD 21502 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JUL 07 1995 | | | | 32. REGISTRAR'S SIGNATURE Julia Annan Randall | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL DR. ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 21822

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|--|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) VERNIE E. HIPSLEY | | | | 2. DATE OF DEATH MONTH Jul , DAY 3 , YEAR 1995 | | 3. TIME OF DEATH 12:45 P M | |
| 4. SOCIAL SECURITY NUMBER 220-10-8773 | | 5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 91 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) May 10, 1904 | |
| 8. BIRTHPLACE (State or Foreign Country) VA | | | | 9a. FACILITY NAME (If not institution, give street and number) CUMBERLAND NURSING CENTER | | 9b. CITY, TOWN OR LOCATION OF DEATH CUMBERLAND | |
| 9c. COUNTY OF DEATH ALLEGANY | | | | 10a. STATE MD | | 10b. COUNTY Allegany | |
| 10c. CITY, TOWN OR LOCATION Cumberland | | | | 10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 10e. STREET AND NUMBER 121 Pennsylvania Avenue | |
| 10f. ZIP CODE 21502 | | | | 10g. CITIZEN OF WHAT COUNTRY? USA | | 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: white | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) College | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Homemaker | | 16b. KIND OF BUSINESS/INDUSTRY Own Home | |
| 17. FATHER'S NAME (First, Middle, Last) Charles B. Davis | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Martha V. (Hinkle) | | | |
| 19a. INFORMANT'S NAME (Type/Print) Vivian G. Boyd | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) RD 6 Box 646; Bedford, PA 15522 | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Hillcrest Burial Park 07/07 | | 20c. LOCATION — City or Town, State Cumberland, MD | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Nicholas J. Scarpelli</i> | | | | 22. NAME AND ADDRESS OF FACILITY Scarpelli Funeral Home Cumberland, MD 21502 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Coronary artery disease DUE TO (OR AS A CONSEQUENCE OF): Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Approximate Interval Between Onset and Death 10 years | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Diabetes mellitus | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | |
| 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | 28d. DESCRIBE HOW INJURY OCCURRED | | | |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER <i>Sunil K. Gupta</i> | | | | 29c. LICENSE NUMBER 33280 | | 29d. DATE SIGNED (Month, Day, Year) July 5, 1995 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Sunil K. Gupta, M.D. 625 Kent Avenue; Cumberland, MD 21502 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JUL 07 1995 | | | | 32. REGISTRAR'S SIGNATURE <i>John B. ...</i> | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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95 21823

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | |
|---|--|--|--|--|--|---|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) EARL HEATH | | | | 2. DATE OF DEATH MONTH 6 DAY 18 YEAR 95 | | 3. TIME OF DEATH 1620 P M | | |
| 4. SOCIAL SECURITY NUMBER 221-20-9890 | | 5. SEX MALE <input type="checkbox"/> F <input checked="" type="checkbox"/> M | | 6. AGE (In yrs. last birthday) 69 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 12-24-25 | | |
| 9a. FACILITY NAME (If not institution, give street and number) UNION HOSPITAL | | | | 9b. CITY, TOWN OR LOCATION OF DEATH ELKTON MD | | 9c. COUNTY OF DEATH CECIL | | |
| RESIDENCE OF DECEDENT | | | | | | | | |
| 10a. STATE DELAWARE | | 10b. COUNTY NEW CASTLE | | 10c. CITY, TOWN OR LOCATION TOWNSEND | | 10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | |
| 10e. STREET AND NUMBER 644 SOUTH STREET | | | | 10f. ZIP CODE 19734 | | 10g. CITIZEN OF WHAT COUNTRY? USA | | |
| 11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: BLACK | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 8th College (1-4 or 5+) | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) LABOR | | 16b. KIND OF BUSINESS/INDUSTRY FARM | | |
| 17. FATHER'S NAME (First, Middle, Last) FLOYD HARRIS DEC | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) FIBY HEATH DEC | | | | |
| 19a. INFORMANT'S NAME (Type/Print) IRENE HEATH | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 644 SOUTH STREET TOWNSEND DE 19734 | | | | |
| 20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input checked="" type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) MASSEY CEMETERY | | DATE 6/24 | | 20c. LOCATION — City or Town, State SMYRNA DE | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Edward H. [Signature]</i> | | | | 22. NAME AND ADDRESS OF FACILITY MINUS FUNERAL HOME DOVER DE 19904 | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → acute myocardial infarction Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST Advanced obstructive and obstructive airway disease PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. pseudomonas pneumonia & left lung | | | | | | | Approximate Interval Between Onset and Death | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | |
| 27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | |
| 28d. DESCRIBE NOW INJURY OCCURRED | | | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | 28g. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | |
| 29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER <i>Kenneth Lewis</i> | | | | 29c. LICENSE NUMBER 019043 | | 29d. DATE SIGNED (Month, Day, Year) 6/19/95 | | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) KENNETH LEWIS, MD, 12 PENNINGTON ST, MIDDLETOWN, DE 19709 | | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JUL 03 '95 | | | | 32. REGISTRAR'S SIGNATURE <i>Gelia Davidson-Randall</i> | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| 1 - FOR STATE REGISTRAR | | STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | CERTIFICATE OF DEATH | | REG. NO. | |
|---|--|--|--|---|---|---|---|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) JOHN RICHARD HIGGS Sr. | | | | | | 2. DATE OF DEATH MONTH JULY 3 DAY 1995 YEAR | | 3. TIME OF DEATH 6:58P M | |
| 4. SOCIAL SECURITY NUMBER 220-52-1046 | | 5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 42 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) April 4, 1953 | | 8. BIRTHPLACE (State or Foreign Country) Maryland | |
| 9a. FACILITY NAME (If not institution, give street and number) JOHNS HOPKINS HOSPITAL | | | | 9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE | | | 9c. COUNTY OF DEATH Baltimore City | | |
| RESIDENCE OF DECEDENT | | | | | | | | | |
| 10a. STATE Maryland | | 10b. COUNTY Queen Annes | | 10c. CITY, TOWN OR LOCATION Centreville | | | 10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | |
| 10e. STREET AND NUMBER 112 Thisitville Circle | | | | 10f. ZIP CODE 21617 | | 10g. CITIZEN OF WHAT COUNTRY? United States | | | |
| 11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | | 14. RACE — American Indian, Black, White, etc. Specify: White | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (9-12) 11 College (1-4 or 5+) 11 | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Agriculture Technician III | | | 16b. KIND OF BUSINESS/INDUSTRY Agriculture | | | | |
| 17. FATHER'S NAME (First, Middle, Last) William Howard Higgs II | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Phyllis Lee Bostie | | | | | |
| 19a. INFORMANT'S NAME (Type/Print) Mrs Betty Jane Higgs | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 112 Thisitville Circle, Centreville, Maryland 21617 | | | | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Chester Cemetery - July 7, 1995 | | DATE July 7, 1995 | | 20c. LOCATION — City or Town, State Chestertown, Maryland | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE William L. King Jr. | | | | 22. NAME AND ADDRESS OF FACILITY Fellows Funeral Homes, P.A. 413 W. High Street - Chestertown, Maryland | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Multiple Injuries DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. | | | | | | | | Approximate Interval Between Onset and Death | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying causes given in Part I. | | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | |
| 27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) 7/3/95 | | 28b. TIME OF INJURY 1609 M | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED Motorcyclist in accident | |
| | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) STREET | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) Carmichael + Overlook Dr. | | | |
| 29a. CERTIFIER (Check one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. SIGNATURE AND TITLE OF CERTIFIER J. CAROL WOLKE MD | | | | 29c. LICENSE NUMBER O.C.M.E. | | 29d. DATE SIGNED (Month, Day, Year) JULY 4, 1995 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) J. CAROL WOLKE MD 111 Penn Street, Baltimore, Maryland 21201 | | | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JUL 06 '95 | | | | 32. REGISTRAR'S SIGNATURE Julia Davidson-Randall | | | | | |

95 21825

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|---|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) Rodger Scott Harrison | | | | 2. DATE OF DEATH MONTH DAY YEAR June 8, 1995 | | 3. TIME OF DEATH 11.00 A. M. | |
| 4. SOCIAL SECURITY NUMBER 006-16-2671 | | 5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (in yrs. last birthday) 78 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) April 8, 1917 | |
| 8. FACILITY NAME (If not institution, give street and number) 306 River Road (AT HOME) | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Chestertown | | 9c. COUNTY OF DEATH Queen Anne | |
| 10a. STATE Maryland | | | | 10b. COUNTY Queen Anne | | 10c. CITY, TOWN OR LOCATION Chestertown | |
| 10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | 10e. STREET AND NUMBER 306 River Road | | | |
| 10f. ZIP CODE 21620 | | | | 10g. CITIZEN OF WHAT COUNTRY? United States | | | |
| 11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES WW II | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 5 | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Associate Publisher | | 16b. KIND OF BUSINESS/INDUSTRY Magazine | |
| 17. FATHER'S NAME (First, Middle, Last) Shelby M. Harrison | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Adelina Rodgers | | | |
| 19a. INFORMANT'S NAME (Type/Print) Mrs. Priscilla D. Harrison | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 306 River Road, Chestertown, Maryland 21620 | | | |
| 20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Capitol Crematory - June 9, 1995 | | 20c. LOCATION — City or Town, State Dover, Delaware | | 21. SIGNATURE OF FUNERAL SERVICE LICENSEE William L. King Jr. | |
| 22. NAME AND ADDRESS OF FACILITY Fellows - Wells Funeral Home | | 22. NAME AND ADDRESS OF FACILITY 413 West High Street - Chestertown, Maryland 21620 | | 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → myocardial infarction DUE TO (OR AS A CONSEQUENCE OF): Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | |
| 26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | 27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | | |
| 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED | |
| 28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | 29b. SIGNATURE AND TITLE OF CERTIFIER [Signature] | | | |
| 29c. LICENSE NUMBER 12-13824 | | | | 29d. DATE SIGNED (Month, Day, Year) 6-8-95 | | | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JUN 13 '95 | | | | 32. REGISTRAR'S SIGNATURE [Signature] | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 21826

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) WALTER HAMPTON | | | | 2. DATE OF DEATH MONTH JUNE DAY 6 YEAR 1995 | | 3. TIME OF DEATH 0235 P M | |
| 4. SOCIAL SECURITY NUMBER 222-60-7966 | | 5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 16 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) December 30, 1978 | |
| 8. BIRTHPLACE (State or Foreign Country) Delaware | | | | 9a. FACILITY NAME (If not institution, give street and number) Bay View Burn Center | | 9b. CITY, TOWN OR LOCATION OF DEATH Baltimore | |
| 9c. COUNTY OF DEATH City | | | | 10a. STATE Maryland | | 10b. COUNTY Kent | |
| 10c. CITY, TOWN OR LOCATION Golts | | | | 10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | 10e. STREET AND NUMBER 13404 Golts Caldwell Road | |
| 10f. ZIP CODE 21637 | | | | 10g. CITIZEN OF WHAT COUNTRY? United States | | 11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: Black | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 11 College (1-4 or 5+) 11 | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Student | | 16b. KIND OF BUSINESS/INDUSTRY Kent County High School | |
| 17. FATHER'S NAME (First, Middle, Last) Walter W. Hampton | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Jennie O'Neal | | | |
| 19a. INFORMANT'S NAME (Type/Print) Catherine Ransom | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13404 Golts Caldwell Road, Golts, Maryland 21637 | | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Glenwood Cemetery 6/12/95 | | 20c. LOCATION — City or Town, State Smyrna, Delaware | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Gary B. Fellows</i> | | | | 22. NAME AND ADDRESS OF FACILITY Fellows Funeral Homes, P.A. 21651 370 W. Cypress Street, Millington, Maryland | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. | | | | | | | |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → 95% BURN WITH INHALATIONAL INJURY | | | | | | | |
| DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| SUBDURAL HEMATOMA | | | | | | | |
| DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/> | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | |
| 27. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide | | | | 28a. DATE OF INJURY (Month, Day, Year) JUNE 5 1995 | | 28b. TIME OF INJURY 1900 M | |
| 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | 28d. DESCRIBE HOW INJURY OCCURRED Motorcycle accident | | | |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) Street | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) Golts - Caldwell Rd Van Dyke Rd | | | |
| 29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER <i>Dr. Rocco</i> Surgical Intern | | | | 29c. LICENSE NUMBER MS307 | | 29d. DATE SIGNED (Month, Day, Year) JUNE 6 1995 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) James William Rocco Johns Hopkins Hospital | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JUN 13 '95 | | | | 32. REGISTRAR'S SIGNATURE <i>John Davidson-Randall</i> | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 21827

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) William Golds Hamilton | | | | 2. DATE OF DEATH MONTH DAY YEAR June 3 1995 | | 3. TIME OF DEATH 0010 M | |
| 4. SOCIAL SECURITY NUMBER 212-16-7313 | | 5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 84 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 12-12-1910 | |
| 9a. FACILITY NAME (If not institution, give street and number) Kent & Queen Anne's Hospital, Inc., | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Chestertown Maryland | | 9c. COUNTY OF DEATH Kent County | |
| RESIDENCE OF DECEDENT | | | | | | | |
| 10a. STATE md. | | 10b. COUNTY Kent | | 10c. CITY, TOWN OR LOCATION Chestertown, md | | 10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 10e. STREET AND NUMBER 9030 FAIRLEE | | | | 10f. ZIP CODE 21620 | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A | |
| 11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: BLACK | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 0-12 College (1-4 or 5+) College (1-4 or 5+) | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) CARE TAKER | | 16b. KIND OF BUSINESS/INDUSTRY KENT CO. CONA. ISSUERS | | | |
| 17. FATHER'S NAME (First, Middle, Last) SAMUEL HAMILTON | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) JULIA MAX | | | |
| 19a. INFORMANT'S NAME (Type/Print) MRS. IRENE HAMILTON | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9030 FAIRLEE RD. CHESTERTOWN, MD 21620 | | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) JANE'S CEMETERY 6/19/95 CHESTERTOWN, MD. | | 20c. LOCATION — City or Town, State | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Kenneth W. Wally | | | | 22. NAME AND ADDRESS OF FACILITY WALLET FUNERAL HOME CHESTERTOWN, MD - 21620 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <u>CONGESTIVE HEART FAILURE</u> DUE TO (OR AS A CONSEQUENCE OF): b. <u>ISCHEMIC CORONARY ARTERY DISEASE</u> DUE TO (OR AS A CONSEQUENCE OF): c. _____ DUE TO (OR AS A CONSEQUENCE OF): d. _____ Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | | Approximate Interval Between Onset and Death 6 MYS 5 MYS |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>ASTHMA</u> <u>CHRONIC RENAL FAILURE</u> DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28d. DESCRIBE NOW INJURY OCCURRED | | | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| 29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER John E. Seymour | | | | 29c. LICENSE NUMBER D-13824 | | 29d. DATE SIGNED (Month, Day, Year) 6-3-95 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) John E. Seymour 122 SPEER RD. CHESTERTOWN, MD | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JUN 13 '95 | | | | 32. REGISTRAR'S SIGNATURE John Davidson | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|--|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) Jared Lee Harper | | | | 2. DATE OF DEATH May 29 1995 | | 3. TIME OF DEATH 1638 | |
| 4. SOCIAL SECURITY NUMBER 314-92-0148 | | 5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 18 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) April 11, 1977 | |
| 8. BIRTHPLACE (State or Foreign Country) Kentucky | | 9a. FACILITY NAME (If not institution, give street and number) Kent-Queen Anne Hospital | | 9b. CITY, TOWN OR LOCATION OF DEATH Chestertown | | 9c. COUNTY OF DEATH Kent | |
| 10a. STATE Maryland | | | | 10b. COUNTY Kent | | 10c. CITY, TOWN OR LOCATION Kennedyville | |
| 10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | 10e. STREET AND NUMBER 12080 Augustine Herman Highway | | 10f. ZIP CODE 21645 | |
| 10g. CITIZEN OF WHAT COUNTRY? United States | | | | 11. MARITAL STATUS 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES 1995 - Present | |
| 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | | | 14. RACE — American Indian, Black, White, etc. Specify: White | | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) College (1-4 or 5+) | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Student - National Guard | | 16b. KIND OF BUSINESS/INDUSTRY Military - National Guard | |
| 17. FATHER'S NAME (First, Middle, Last) Johnnie R. Harper | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Alice Lee | | | |
| 19a. INFORMANT'S NAME (Type/Print) Johnnie R. Harper | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12080 Augustine Herman Highway - Kennedyville, Maryland | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Shrewsbury Cemetery - June 2, 1995 | | 20c. LOCATION — City or Town, State Kennedyville, Maryland | | 21. SIGNATURE OF FUNERAL SERVICE LICENSEE William L. King Jr. | |
| 22. NAME AND ADDRESS OF FACILITY Fellows - Wells Funeral Home 413 West High Street, Chestertown, Maryland 21620 | | | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. DROWNING DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input checked="" type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) 5/29/95 | | 28b. TIME OF INJURY 1600 PM | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED SUBJECT DROWNED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) CREEK | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) TURNERS CREEK, KENT COUNTY | | | |
| 29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER MARIO F. GOW JR. MD | | | | 29c. LICENSE NUMBER O.C.M.E. | | 29d. DATE SIGNED (Month, Day, Year) May 30 1995 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) MARIO F. GOW JR. MD 111 Penn Street, Baltimore Maryland 21201 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JUN 01 '95 | | 32. REGISTRAR'S SIGNATURE John Davidson-Randall | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 21829

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|--|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) Marie Sarah Hammill | | | | 2. DATE OF DEATH MONTH DAY YEAR July 4, 1995 | | 3. TIME OF DEATH 1747 hrs M | |
| 4. SOCIAL SECURITY NUMBER 213-16-7776 | | 5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 85 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) December 13, 1909 | |
| 8. BIRTHPLACE (State or Foreign Country) Maryland | | | | 9a. FACILITY NAME (If not institution, give street and number) 24839 Smithville Road (AT HOME) | | 9b. CITY, TOWN OR LOCATION OF DEATH Worton | |
| 9c. COUNTY OF DEATH Kent | | | | 10a. STATE Maryland | | 10b. COUNTY Kent | |
| 10c. CITY, TOWN OR LOCATION Worton | | | | 10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 10e. STREET AND NUMBER 24839 Smithville Road | |
| 10f. ZIP CODE 21678 | | | | 10g. CITIZEN OF WHAT COUNTRY? United States | | 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 11 College (1-4 or 5 +) | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Auto Seat Maker | | 16b. KIND OF BUSINESS/INDUSTRY Automotive | |
| 17. FATHER'S NAME (First, Middle, Last) Richard Thomas Hewitt | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Mary Jeanette Powell | | | |
| 19a. INFORMANT'S NAME (Type/Print) Oliver Hewitt | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 24840 Montabello Lake Road, Worton, Maryland 21678 | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Church Hill Cemetery - July 7, 1995 | | 20c. LOCATION — City or Town, State Church Hill, Maryland | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE William L. King Jr. | | | | 22. NAME AND ADDRESS OF FACILITY Fellows - Wells Funeral Home 413 West High Street, Chestertown, Maryland 21620 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <i>Ca of lung</i> DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>COPD</i> | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | |
| 27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined | | | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | 28d. DESCRIBE HOW INJURY OCCURED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER <i>C. G. Bauman</i> | | | | 29c. LICENSE NUMBER D00 354 | | 29d. DATE SIGNED (Month, Day, Year) 7/6/95 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) C. G. Bauman Brown St. Chestertown, Md 21620 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) Jul 07 '95 | | | | 32. REGISTRAR'S SIGNATURE <i>John Davidson-Randall</i> | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 21830

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | | | |
|--|--|--|--|--|--|---|--|--|---|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) <u>WELSON</u> | | | | 2. DATE OF DEATH MONTH <u>JULY</u> DAY <u>5</u> YEAR <u>1995</u> | | | | 3. TIME OF DEATH <u>0135 A.</u> | | | |
| 4. SOCIAL SECURITY NUMBER <u>578-64-6942</u> | | | | 5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) <u>73</u> YRS. | | 7. DATE OF BIRTH (Month, Day, Year) <u>Nov. 17, 1921</u> | | 8. BIRTHPLACE (State or Foreign Country) <u>China</u> | |
| 9a. FACILITY NAME (If not institution, give street and number) <u>Shady Grove Adventist Hospital</u> | | | | | | 9b. CITY, TOWN OR LOCATION OF DEATH <u>Rockville</u> | | | 9c. COUNTY OF DEATH <u>Montgomery</u> | | |
| RESIDENCE OF DECEDENT | | | | | | | | | | | |
| 10a. STATE <u>Maryland</u> | | | 10b. COUNTY <u>Montgomery</u> | | | 10c. CITY, TOWN OR LOCATION <u>Gaithersburg</u> | | | 10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | |
| 10e. STREET AND NUMBER <u>110 Twelve Oaks Court</u> | | | | | | 10f. ZIP CODE <u>20878</u> | | | 10g. CITIZEN OF WHAT COUNTRY? <u>USA</u> | | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | | 14. RACE — American Indian, Black, White, etc. Specify: <u>Asian</u> | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <u>12</u> College (1-4 or 5+) <u>4</u> | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <u>Accountant</u> | | | | 16b. KIND OF BUSINESS/INDUSTRY <u>Brookings Institution</u> | | | |
| 17. FATHER'S NAME (First, Middle, Last) <u>Unobtainable</u> | | | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) <u>Unobtainable</u> | | | | | |
| 19a. INFORMANT'S NAME (Type/Print) <u>Sharon S. Jen</u> | | | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>110 Twelve Oaks Court, Gaithersburg, Maryland 20878</u> | | | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <u>Gate of Heaven Cemetery</u> | | | | DATE <u>7/8</u> | | 20c. LOCATION — City or Town, State <u>Silver Spring, Maryland</u> | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <u>James L. Phillips</u> | | | | | | 22. NAME AND ADDRESS OF FACILITY <u>Hines-Rinaldi Funeral Home</u> <u>11800 New Hampshire Avenue</u> <u>Silver Spring, Maryland 20904</u> | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | | | | | |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | | | | | | | | | | Approximate Interval Between Onset and Death | |
| a. <u>metastatic gastric cancer</u> | | | | | | | | | | <u>2 1/2 years</u> | |
| DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | | | |
| b. <u>congestive heart failure</u> | | | | | | | | | | <u>one day</u> | |
| DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | | | |
| c. <u>severe malnutrition</u> | | | | | | | | | | <u>one year</u> | |
| DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | | | |
| d. <u>dehydration</u> | | | | | | | | | | <u>one week</u> | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | | | | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide 4 <input type="checkbox"/> Other | | | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY <u>M</u> | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED | |
| 28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | | | 29f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER <u>Dr. [Signature]</u> | | | | | | 29c. LICENSE NUMBER <u>D34969</u> | | | 29d. DATE SIGNED (Month, Day, Year) <u>July 5, 1995</u> | | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <u>9707 Medical Center Dr. Suite 320 Rockville, MD 20850</u> | | | | | | | | | | | |
| 31. DATE FILED (Month, Day, Year) <u>JUL 07 1995</u> | | | | 32. REGISTRAR'S SIGNATURE <u>John [Signature]</u> | | | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL DR. ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 21831

ITEM: 2. PER DR. FILM G-727 9/13/95 t.t

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|---|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) JOSEPH CLINTON JOYNER | | | | 2. DATE OF DEATH MONTH 06 DAY 29 YEAR 95 | | 3. TIME OF DEATH 10:28 P M | |
| 4. SOCIAL SECURITY NUMBER 243-01-4801 | | 5. SEX 1 M 2 F | | 6. AGE (in yrs. last birthday) 75 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) April 24, 1920 | |
| 8. BIRTHPLACE (State or Foreign Country) North Carolina | | | | 9a. FACILITY NAME (If not institution, give street and number) Holy Cross Hospital | | 9b. CITY, TOWN OR LOCATION OF DEATH Silver Spring | |
| 9c. COUNTY OF DEATH Montgomery | | | | 10a. STATE Maryland | | 10b. COUNTY Montgomery | |
| 10c. CITY, TOWN OR LOCATION Silver Spring | | | | 10d. INSIDE CITY LIMITS? 1 YES 2 NO | | 10e. STREET AND NUMBER 204 Crestmoor Circle | |
| 10f. ZIP CODE 20901 | | | | 10g. CITIZEN OF WHAT COUNTRY? USA | | 11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced | |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES | | | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 YES 2 NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (9-12) 8 | | | | 16. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Manager | | 16b. KIND OF BUSINESS/INDUSTRY Food Service | |
| 17. FATHER'S NAME (First, Middle, Last) Willie Wright Joyner | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Ella Joyner | | | |
| 19a. INFORMANT'S NAME (Type/Print) Susan Mattingly | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4012 Jefferson Street Hyattsville, Maryland 20781 | | | |
| 20a. METHOD OF DISPOSITION 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) | | | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Gate of Heaven Cemetery 7/5/95 Silver Spring, Maryland | | 20c. LOCATION — City or Town, State | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Steven D. Stroud | | | | 22. NAME AND ADDRESS OF FACILITY Francis J. Collins Funeral Home, Inc. 500 University Blvd. W. Sil. Spr. MD 20901 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Peritonitis DUE TO (OR AS A CONSEQUENCE OF): b. Bowel Perforation DUE TO (OR AS A CONSEQUENCE OF): c. Branched arteries, bowel disease DUE TO (OR AS A CONSEQUENCE OF): d. Approximate Interval Between Onset and Death 24 hrs 48 hrs 6+ months | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Lung Cancer, atrial fibrillation, Renal failure | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED? 1 YES 2 NO | | | | | | | |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO | | | | | | | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 Inpatient 2 ER/Outpatient 3 DOA OTHER: 4 Nursing Home 5 Residence 6 Other (Specify) | | | | | |
| 27. MANNER OF DEATH 1 Natural 2 Accident 3 Suicide 4 Homicide 5 Pending Investigation 6 Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 YES 2 NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one) 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER Ernest S. Oser, M.D. | | | | 29c. LICENSE NUMBER DO3792 | | 29d. DATE SIGNED (Month, Day, Year) July 2, 1995 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Ernest S. Oser, M.D. 10301 Georgia Ave. #304, Silver Spring, MD 20902-5088 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JUL 03 1995 | | | | 32. REGISTRAR'S SIGNATURE John Davidson Randall | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) MICHAEL D. JONES | | | | 2. DATE OF DEATH MONTH JUNE DAY 27 YEAR 1995 | | 3. TIME OF DEATH 2:35 A M | |
| 4. SOCIAL SECURITY NUMBER 212-06-2342 | | 5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 27 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) JULY 27 1967 | |
| 8. BIRTHPLACE (State or Foreign Country) MARYLAND | | | | 9. FACILITY NAME (If not institution, give street and number) ANNE ARUNDEL MEDICAL CENTER | | 10. CITY, TOWN OR LOCATION OF DEATH ANNAPOLIS | |
| 11. RESIDENCE OF DECEDENT 10a. STATE MARYLAND 10b. COUNTY ANNE ARUNDEL 10c. CITY, TOWN OR LOCATION ARNOLD | | | | 12. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | 13. STREET AND NUMBER 57 OLD FREDERICK ROAD | |
| 14. ZIP CODE 21012 | | | | 15. CITIZEN OF WHAT COUNTRY? USA | | 16. MARRIAGE STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | |
| 17. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | | | 18. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 19. RACE — American Indian, Black, White, etc. Specify: BLACK | |
| 20. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (9-12) 12th College (1-4 or 5+) 0 | | | | 21. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) UNEMPLOYED | | 22. KIND OF BUSINESS/INDUSTRY NONE | |
| 23. FATHER'S NAME (First, Middle, Last) WILSON D. JONES | | | | 24. MOTHER'S NAME (First, Middle, Maiden Surname) MARY L. ROGERS | | | |
| 25. INFORMANT'S NAME (Type/Print) WILSON D. JONES | | | | 26. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 57 OLD FREDERICK RD. ARNOLD, MD. 21012 | | | |
| 27. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input checked="" type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 28. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) ANNAPOLIS MEM. GARDENS 7/3/95 | | 29. LOCATION — City or Town, State ANNAPOLIS, MD. | |
| 30. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Larry H. Reese</i> | | | | 31. NAME AND ADDRESS OF FACILITY REESE & SONS MORTUARY, P.A. 821 WEST ST. ANNAPOLIS, MD. 21401 | | | |
| 32. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Stab Wound to Front of the Chest DUE TO (OR AS A CONSEQUENCE OF): b. _____ c. _____ d. _____ SEQUENTIALLY LIST CONDITIONS, IF ANY, LEADING TO IMMEDIATE CAUSE. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | |
| 33. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | 34. WAS AN AUTOPSY PERFORMED? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | 35. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | |
| 36. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | 37. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | |
| 38. MANNER OF DEATH 1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input checked="" type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined | | | | 39. DATE OF INJURY (Month, Day, Year) 6/27/95 | | 40. TIME OF INJURY 1:50 A M | |
| 41. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) street | | | | 42. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 43. DESCRIBE HOW INJURY OCCURRED subject stabbed | |
| 44. LOCATION (Street and Number or Rural Route Number, City or Town, State) 57 Old Frederick Rd Arnold Md | | | | 45. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | |
| 46. SIGNATURE AND TITLE OF CERTIFIER <i>Dennis J. Chute M.D.</i> | | | | 47. LICENSE NUMBER O.C.M.E. | | 48. DATE SIGNED (Month, Day, Year) JUNE 27, 1995 | |
| 49. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Dennis Chute M.D. 111 Penn Street, Baltimore, Maryland 21201 | | | | | | | |
| 50. DATE FILED (Month, Day, Year) JUL 10 1995 | | | | 51. REGISTRAR'S SIGNATURE <i>John Davidson Randall</i> | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 21833

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|---|--|--|---|
| 1. DECEDENT'S NAME (First, Middle, Last) NELLIE YARNELL JENKINS | | | | 2. DATE OF DEATH MONTH JULY DAY 5 YEAR 1995 | | 3. TIME OF DEATH 00:10 A^M | |
| 4. SOCIAL SECURITY NUMBER 224-54-3659 | | 5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 87 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) Sep 12, 1907 | |
| 9a. FACILITY NAME (If not institution, give street and number) SACRED HEART HOSPITAL | | | | 9b. CITY, TOWN OR LOCATION OF DEATH CUMBERLAND | | 9c. COUNTY OF DEATH ALLEGANY | |
| 10a. STATE MD | | | | 10b. COUNTY Allegany | | 10c. CITY, TOWN OR LOCATION Cumberland | |
| 10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | | | | |
| 10e. STREET AND NUMBER 900 Bishop Walsh Drive | | | | 10f. ZIP CODE 21502 | | 10g. CITIZEN OF WHAT COUNTRY? USA | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: white | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) College (1-4 or 5+) | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Owner/Operator | | 16b. KIND OF BUSINESS/INDUSTRY Goose Creek Country Club | | | |
| 17. FATHER'S NAME (First, Middle, Last) William Edward Chapline | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Helena Murray (Connell) | | | |
| 19a. INFORMANT'S NAME (Type/Print) Wilford Blough | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 127 Park Avenue: LaVale, MD 21502 | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) SS Peter Paul Cemetery | | 20c. LOCATION — City or Town, State 07/10 Cumberland, MD | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Nicholas J. Scarpelli</i> | | | | 22. NAME AND ADDRESS OF FACILITY Scarpelli Funeral Home Cumberland, MD 21502 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. SEPTICEMIA DUE TO (OR AS A CONSEQUENCE OF): Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. | | | | | | | Approximate interval Between Onset and Death 2 DAYS |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. MASSIVE Right Cerebral Infarct CONGESTIVE HEART FAILURE CORONARY ARTERY DISEASE DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 6 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER SATURNINA CHANG S Chang MD | | | | 29c. LICENSE NUMBER D25638 | | 29d. DATE SIGNED (Month, Day, Year) JULY 6, 1995 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) SATURNINA CHANG Rt 36 FROSTBURG PLAZA FROSTBURG MARYLAND 21532 | | | | | | | |
| 31. DATE OF DEATH (Month, Day, Year) JUL 07 1995 | | 32. MEDICAL EXAMINER'S SIGNATURE <i>Donald R. Bell</i> | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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95 21834

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) IVORY SYLVESTER JOHNSON | | | | 2. DATE OF DEATH MONTH 5 - DAY 21 - YEAR 95 | | 3. TIME OF DEATH 1:00 P.M. | |
| 4. SOCIAL SECURITY NUMBER 197-09-3387 | | 5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 100 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 3-10-1895 | |
| 8. BIRTHPLACE (State or Foreign Country) MD. | | | | 9a. FACILITY NAME (If not institution, give street and number) KENT-QUEEN ANNES HOSPITAL | | 9b. CITY, TOWN OR LOCATION OF DEATH CHESTERTOWN | |
| 9c. COUNTY OF DEATH Kent | | | | 10a. STATE MD. | | 10b. COUNTY Kent | |
| 10c. CITY, TOWN OR LOCATION CHESTERTOWN | | | | 10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 10e. STREET AND NUMBER 7485 ROLLAR AVE | |
| 10f. ZIP CODE 21620 | | | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | | 11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES WWII | | | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: BLACK | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 0-8 College (1-4 or 5+) College | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) LANDSCAPER | | 16b. KIND OF BUSINESS/INDUSTRY YARDS | |
| 17. FATHER'S NAME (First, Middle, Last) Willie Johnson | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Mollie Butler | | | |
| 19a. INFORMANT'S NAME (Type/Print) MRS. VIVIAN COMEY | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) WALLET FUNERAL HOME, CHESTERTOWN, MD. 21620 | | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) SAKE'S CEMETERY, 5/21/95, CHESTERTOWN, MD. | | 20c. LOCATION — City or Town, State | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Donna Wally | | | | 22. NAME AND ADDRESS OF FACILITY WALLET FUNERAL HOME, CHESTERTOWN, MD. 21620 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Pneumonia DUE TO (OR AS A CONSEQUENCE OF): Approximate Interval Between Onset and Death: 6 days Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST: b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Advanced age | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 28. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER K. K. WUN, MD. | | | | 29c. LICENSE NUMBER D21313 | | 29d. DATE SIGNED (Month, Day, Year) 5/24/95 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) KIN K. WUN, 216 High St., Chestertown, MD, 21620 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) MAY 26 '95 | | | | 32. REGISTRAR'S SIGNATURE G. Davidson-Randall | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 21835

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | |
|---|--|---|---|---|-------------------------------------|--|---|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) Elmer O. Jones Jr | | | | 2. DATE OF DEATH MONTH DAY YEAR June 17, 1995 | | | | 3. TIME OF DEATH 6:30 a. m | |
| 4. SOCIAL SECURITY NUMBER 213-22-8227 | | 5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | 6. AGE (In yrs. last birthday) 65 YRS. | 7. DATE OF BIRTH (Month, Day, Year) April 25, 1930 | | 8. BIRTHPLACE (State or Foreign Country) Maryland | | | |
| 9a. FACILITY NAME (If not institution, give street and number) 21386 Catholic Avenue - (AT HOME) | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Rock Hall | | | 9c. COUNTY OF DEATH Kent | | |
| RESIDENCE OF DECEDENT | | | | | | | | | |
| 10a. STATE Maryland | | 10b. COUNTY Kent | | 10c. CITY, TOWN OR LOCATION Rock Hall | | | 10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | |
| 10e. STREET AND NUMBER 21386 Catholic Avenue | | | | 10f. ZIP CODE 21661 | | 10g. CITIZEN OF WHAT COUNTRY? United States | | | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | | 14. RACE — American Indian, Black, White, etc. Specify: White | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 12 | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Rural Route Carrier | | | 16b. KIND OF BUSINESS/INDUSTRY U.S. Postal Service | | |
| 17. FATHER'S NAME (First, Middle, Last) Elmer O. Jones Sr. | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Rosalie C. Williams | | | | | |
| 19a. INFORMANT'S NAME (Type/Print) Evelyn L. Jones | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) Catholic Avenue, Rock Hall, Maryland 21661 | | | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) St. Johns Cemetery - June 20, 1995 Rock Hall, Maryland | | | 20c. LOCATION — City or Town, State | | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE William L. King Jr. | | | | 22. NAME AND ADDRESS OF FACILITY Fellows - Wells Funeral Home Maryland Route 20, Rock Hall, Maryland 21661 | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <u>ROSTALINZLY PAIN</u> DUE TO (OR AS A CONSEQUENCE OF): b. <u>SMALL CORONARY ARTERY - CUL</u> DUE TO (OR AS A CONSEQUENCE OF): c. _____ DUE TO (OR AS A CONSEQUENCE OF): d. _____ Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | | | Approximate Interval Between Onset and Death 10 DAYS 8 MONTHS | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | | | | | | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Homicide 4 <input type="checkbox"/> Undetermined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED | |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER J. C. Seymour M.D. | | | | 29c. LICENSE NUMBER D-13824 | | 29d. DATE SIGNED (Month, Day, Year) 6-21-95 | | | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) | | | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JUN 23 '95 | | | | 32. REGISTRAR'S SIGNATURE Julia Davidson-Randall | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 21836

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|--|--|---|--|--|---|
| 1. DECEDENT'S NAME (First, Middle, Last) Lucille Josephine Jones | | | | 2. DATE OF DEATH MONTH DAY YEAR June 13 1995 | | 3. TIME OF DEATH 0311 | |
| 4. SOCIAL SECURITY NUMBER 216-18-2561 | | 5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 73 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 3-4-1923 | |
| 8. BIRTHPLACE (State or Foreign Country) MD. | | | | 9a. FACILITY NAME (If not institution, give street and number) The Kent & Queen Anne's Hospital Inc. | | 9b. CITY, TOWN OR LOCATION OF DEATH Chestertown | |
| 9c. COUNTY OF DEATH Kent | | | | | | | |
| 10a. STATE MD. | | | | 10b. COUNTY Kent | | 10c. CITY, TOWN OR LOCATION WORTON | |
| 10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | | | | |
| 10e. STREET AND NUMBER 25629 W. Hill Rd. | | | | 10f. ZIP CODE 21678 | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: BLACK | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 0-8 College (1-4 or 5+) College | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) DOMESTIC | | 16b. KIND OF BUSINESS/INDUSTRY HOMES | | | |
| 17. FATHER'S NAME (First, Middle, Last) JOHN STOUTS | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) SADIE WALLEY | | | |
| 19a. INFORMANT'S NAME (Type/Print) MR. THOMAS E. JONES, SR. | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 25629 W. Hill Rd. WORTON, MD. 21678 | | | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) NEW CHR. ST. ANCHOR CHAPEL 6/13/95 WORTON, MD. | | 20c. LOCATION — City or Town, State | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Kenneth Walley | | | | 22. NAME AND ADDRESS OF FACILITY WALLEY FUNERAL HOME CHESTERTOWN, MD. 21620 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. CHOLANGIOCARCINOMA DUE TO (OR AS A CONSEQUENCE OF): Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. | | | | | | | Approximate Interval Between Onset and Death 3 months |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. KLEBSIELLA PNEUMONIA | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | | | | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 28d. DESCRIBE NOW INJURY OCCURRED | | | | 28e. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER John A Noble MD | | | | 29c. LICENSE NUMBER D41587 | | 29d. DATE SIGNED (Month, Day, Year) 6-14-95 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) HELEN A. NOBLE 122 SPOOK RD. CHESTERTOWN, MD. 21620 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JUN 20 '95 | | | | 32. REGISTRAR'S SIGNATURE Julia Davidson-Randall | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.




TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 21837

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) Jimmy Ray Kinion | | | | 2. DATE OF DEATH MONTH July DAY 9 YEAR 1995 | | 3. TIME OF DEATH 10 :03 PM | |
| 4. SOCIAL SECURITY NUMBER 218-48-1003 | | 5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 47 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) Feb. 6, 1948 | |
| 8. BIRTHPLACE (State or Foreign Country) North Carolina | | | | 9a. FACILITY NAME (If not institution, give street and number) Southern Maryland Hospital | | 9b. CITY, TOWN OR LOCATION OF DEATH Clinton | |
| 9c. COUNTY OF DEATH Prince George's | | | | 10a. STATE Maryland | | 10b. COUNTY Prince George's | |
| 10c. CITY, TOWN OR LOCATION Clinton | | | | 10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 10e. STREET AND NUMBER 9101 Simpson Lane | |
| 10f. ZIP CODE 20735 | | | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | | 11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES 1969-1970 | | | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: Caucasian | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12th College (1-4 or 5+) 4 | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Parole & Probation Agent | | 16b. KIND OF BUSINESS/INDUSTRY State of Maryland | |
| 17. FATHER'S NAME (First, Middle, Last) Ben Kinion | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Alize Marie Boyd | | | |
| 19a. INFORMANT'S NAME (Type/Print) Jeannette M. Kinion | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9101 Simpson Lane Clinton Maryland 20735 | | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) July 13, 1995 Maryland State Veterans Cem. | | 20c. LOCATION — City or Town, State Cheltenham, Maryland | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE  | | | | 22. NAME AND ADDRESS OF FACILITY Lee Funeral Home, Inc. 6633 Old Alexandria Ferry Rd Clinton, Md 20735 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Cancer of Lung DUE TO (OR AS A CONSEQUENCE OF): a. Metastatic DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Approximate Interval Between Onset and Death 4 months | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | 29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER  | | | | 29c. LICENSE NUMBER D28352 | | 29d. DATE SIGNED (Month, Day, Year) 7-10-95 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Krishan Mathur M.D. 11340 Pembroke Square #213 Waldorf, Md 20603-2729 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JUL 11 1995 | | | | 32. REGISTRAR'S SIGNATURE  | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 21838

ITEM: 17. PER F.H. FILM G-728 10/5/95 t.t

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|---|--|--|---|
| 1. DECEDENT'S NAME (First, Middle, Last) GEORGE CHRISTIAN KRAFT | | | | 2. DATE OF DEATH MONTH JULY DAY 8 YEAR 1995 | | 3. TIME OF DEATH 3:00 P. | |
| 4. SOCIAL SECURITY NUMBER 214-05-8600 | | 5. SEX 1 <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 77 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) OCT. 9, 1917 | |
| 9a. FACILITY NAME (If not institution, give street and number) SACRED HEART HOSPITAL | | | | 9b. CITY, TOWN OR LOCATION OF DEATH CUMBERLAND | | 9c. COUNTY OF DEATH ALLEGANY | |
| RESIDENCE OF DECEDENT | | | | | | | |
| 10a. STATE MARYLAND | | 10b. COUNTY ALLEGANY | | 10c. CITY, TOWN OR LOCATION LAVALE | | 10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | |
| 10e. STREET AND NUMBER 12400 HENRY DRIVE | | | | 10f. ZIP CODE 21502 | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 11. MARITAL STATUS 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES W.W.II | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: WHITE | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) _____ | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) SELF-EMPLOYED | | 16b. KIND OF BUSINESS/INDUSTRY BRICK MASON/ CONSTRUCTION | | | |
| 17. FATHER'S NAME (First, Middle, Last) GEORGE ANDREW KRAFT | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) EDNA MARIE FISHER | | | |
| 19a. INFORMANT'S NAME (Type/Print) EUGENIE KRAFT HABERLEIN | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12400 HENRY DRIVE - LAVALE, MD 21502 | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) _____ | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) ROSE HILL CEMETERY 7/10/95 | | 20c. LOCATION — City or Town, State CUMBERLAND, MD | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Kendy D. Lockunch</i> | | | | 22. NAME AND ADDRESS OF FACILITY GEORGE-UPCHURCH FUNERAL HOME, P.A. 202 GREENE ST., CUMBERLAND, MD 21502 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. CHRONIC OBSTRUCTIVE PULMONARY DISEASE WITH COMPLICATIONS Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. _____ c. _____ d. _____ | | | | | | | Approximate interval Between Onset and Death 10 Yrs. |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ACUTE GASTRIC ULCER | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) _____ | | | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 6 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| | | 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER <i>Paul Snow</i> | | | | 29c. LICENSE NUMBER D09157 | | 29d. DATE SIGNED (Month, Day, Year) JULY 8, 1995 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) PAUL SNOW, M.D.-DEPUTY M.E.-124 W. THIRD ST., CUMBERLAND, MD 21502 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JUL 10 1995 | | | | 32. REGISTRAR'S SIGNATURE <i>John Davidson Randall</i> | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 21839

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|--|--|---|--|--|---|
| 1. DECEDENT'S NAME (First, Middle, Last) LILLIAN KLAVUHN | | | | 2. DATE OF DEATH MONTH DAY YEAR JULY 5 1995 | | 3. TIME OF DEATH 22:45 P M | |
| 4. SOCIAL SECURITY NUMBER 216-18-1979 | | 5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 93 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) Sept. 23, 1901 | |
| 8. BIRTHPLACE (State or Foreign Country) Pennsylvania | | | | 9a. FACILITY NAME (If not institution, give street and number) Memorial Hospital | | 9b. CITY, TOWN OR LOCATION OF DEATH cumberland | |
| 9c. COUNTY OF DEATH Allegany | | | | 10a. STATE Maryland | | 10b. COUNTY Allegany | |
| 10c. CITY, TOWN OR LOCATION cumberland | | | | 10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | 10e. STREET AND NUMBER 615 Yale street | |
| 10f. ZIP CODE 21502 | | | | 10g. CITIZEN OF WHAT COUNTRY? USA | | 11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: white | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) College | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) cook | | 16b. KIND OF BUSINESS/INDUSTRY Nursing Home | |
| 17. FATHER'S NAME (First, Middle, Last) Jake shroyer | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Rose Clites | | | |
| 19a. INFORMANT'S NAME (Type/Print) Daniel Klavuhn | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 201 Princeton St. Cumberland, Md. 21502 | | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) SUNSET Memorial Park 2-8-95 | | 20c. LOCATION — City or Town, State Cumberland, Maryland | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Ernest A. Riley, Jr. | | | | 22. NAME AND ADDRESS OF FACILITY Leisure-STEIN, INC. 230 Baltimore Ave. Cumberland, Md. 21502 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Pneumonia DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. Atrial Fibrillation c. Probable Sepsis d. | | | | | | | Approximate Interval Between Onset and Death 1 Day |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Atrial Fibrillation Probable Sepsis | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO | | | | | | | DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/> |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER Sunil Gupta | | | | 29c. LICENSE NUMBER D 33280 | | 29d. DATE SIGNED (Month, Day, Year) JULY 6, 1995 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) DR. SUNIL GUPTA, JOHNSON HEIGHTS MEDICAL BLDG. CUMBERLAND, MD 21502 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JUL 08 1995 | | | | 32. REGISTRAR'S SIGNATURE [Signature] | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 21840

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) John Lusk Kronau | | | | 2. DATE OF DEATH MONTH DAY YEAR June 6, 1995 | | 3. TIME OF DEATH 1:45 p. M | |
| 4. SOCIAL SECURITY NUMBER 218-14-1194 | | 5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 88 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) Sept. 17, 1906 | |
| 9a. FACILITY NAME (If not institution, give street and number) Royal Swan Farm | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Still Pond | | 9c. COUNTY OF DEATH Kent | |
| RESIDENCE OF DECEDENT | | | | | | | |
| 10a. STATE Maryland | | 10b. COUNTY Kent | | 10c. CITY, TOWN OR LOCATION Still Pond | | 10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| 10e. STREET AND NUMBER 26751 Royal Swan Farm, Still Pond, Maryland | | | | 10f. ZIP CODE 21667 | | 10g. CITIZEN OF WHAT COUNTRY? United States | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 2 | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Civil Engineer | | 16b. KIND OF BUSINESS/INDUSTRY Highway Contractor | | | |
| 17. FATHER'S NAME (First, Middle, Last) Harry Moran Kronau | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Mary E. Eslin | | | |
| 19a. INFORMANT'S NAME (Type/Print) Alma M. Kronau | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 26751 Royal Swan Farm, Still Pond, Maryland 21667 | | | |
| 20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Capitol Crematory 6/7/95 | | 20c. LOCATION — City or Town, State Dover, Delaware | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Sally B. Fellows</i> | | | | 22. NAME AND ADDRESS OF FACILITY Fellows-Wells Funeral Home 413 High Street, Chestertown, Maryland 21620 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <i>Metastatic Prostate Cancer to Bone</i> DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. | | | | | | | Approximate Interval Between Onset and Death |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Metastatic Prostate Cancer to Intramedullary Spine</i> <i>Hypertension ASCVD</i> DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | | | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Nomicide | | 28a. DATE OF INJURY (Month, Day, Year) <i>none</i> | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 28d. DESCRIBE NOW INJURY OCCURRED | | | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER <i>Quab</i> | | | | 29c. LICENSE NUMBER 823889 | | 29d. DATE SIGNED (Month, Day, Year) 6/7/95 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 948 Washington Ave, Chestertown, Md 21620 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JUN 09 '95 | | | | 32. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i> | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 21841

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|---|--|---|--|--|---|
| 1. DECEDENT'S NAME (First, Middle, Last) Norma Ruth Kmiecik | | | | 2. DATE OF DEATH MONTH July DAY 8 YEAR 1995 | | 3. TIME OF DEATH 5:55 A: M | |
| 4. SOCIAL SECURITY NUMBER 217-26-9644 | | 5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 64 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) Feb 18, 1931 | |
| 8. BIRTHPLACE (State or Foreign Country) West Virginia | | | | 9a. FACILITY NAME (If not institution, give street and number) 1A Jenkins Drive | | 9b. CITY, TOWN OR LOCATION OF DEATH Indian Head | |
| 9c. COUNTY OF DEATH Charles | | | | 10a. STATE North Carolina | | 10b. COUNTY Onslow | |
| 10c. CITY, TOWN OR LOCATION Surf City | | | | 10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 10e. STREET AND NUMBER 3080 3rd Street | |
| 10f. ZIP CODE 28445 | | | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | | 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5 +) | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) | | 16b. KIND OF BUSINESS/INDUSTRY | |
| 17. FATHER'S NAME (First, Middle, Last) Thomas Edward Lawlis | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Beulah Elizabeth Grapes Lawlis | | | |
| 19a. INFORMANT'S NAME (Type/Print) Wayne Kmiecik | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1-A Jenkins Drive Indian Head, MD 20640 | | | |
| 20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Metropolitan Crematory 7/8 Alexandria, Virginia | | 20c. LOCATION — City or Town, State | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE M00817 Aughton C. Echols III | | | | 22. NAME AND ADDRESS OF FACILITY Arehart-Echols Funeral Home, Inc. P.O. Box 567 La Plata, MD 20646 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. CANCER OF COLON DUE TO (OR AS A CONSEQUENCE OF): b. METASTATIC DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | | Approximate Interval Between Onset and Death 2 mo |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER Krishan Mathur MD | | | | 29c. LICENSE NUMBER D-28352 | | 29d. DATE SIGNED (Month, Day, Year) 7-8-95 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Krishan Mathur MD 11340 Pembroke Square Suite 213 Waldorf, Md. 20603 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JUL 10 1995 | | | | 32. REGISTRAR'S SIGNATURE Julia Davidson Randall | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 21842

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|---|--|--|-----------------------------------|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) <i>Richard Lord</i> | | | | 2. DATE OF DEATH MONTH <i>07</i> DAY <i>01</i> YEAR <i>95</i> | | 3. TIME OF DEATH <i>8:28 p</i> M | |
| 4. SOCIAL SECURITY NUMBER <i>412-78-9211</i> | | 5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F | 6. AGE (In yrs. last birthday) <i>49</i> YRS. | IF UNDER 1 YEAR MONTHS DAYS | IF UNDER 24 HRS. HOURS MIN. | 7. DATE OF BIRTH (Month, Day, Year) <i>JUNE 27 1946</i> | |
| 8. BIRTHPLACE (State or Foreign Country) <i>TENNESSEE</i> | | | | 9a. FACILITY NAME (If not institution, give street and number) <i>UNIVERSITY HOSPITAL</i> | | 9b. CITY, TOWN OR LOCATION OF DEATH <i>BALTIMORE</i> | |
| 9c. COUNTY OF DEATH | | | | 10a. STATE <i>MARYLAND</i> | | | |
| 10b. COUNTY <i>ANNE ARUNDEL</i> | | 10c. CITY, TOWN OR LOCATION <i>ANNAPOLIS</i> | | 10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | 10e. STREET AND NUMBER <i>98 SPRING VALLEY DRIVE</i> | |
| 10f. ZIP CODE <i>21403</i> | | 10g. CITIZEN OF WHAT COUNTRY? <i>USA</i> | | 11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | |
| 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: <i>WHITE</i> | | 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <i>12th</i> College (1-4 or 5+) <i>4+</i> | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <i>NAVAL ARCHITECT</i> | |
| 16b. KIND OF BUSINESS/INDUSTRY <i>NAVAL SEA SYSTEM</i> | | 17. FATHER'S NAME (First, Middle, Last) <i>RICHARD S. LORD</i> | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) <i>KATHRYN D. HERMANN</i> | | 19a. INFORMANT'S NAME (Type/Print) <i>NINA MAJOR LORD</i> | |
| 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>98 SPRING VALLEY DRIVE ANNAPOLIS, MD. 21403</i> | | 20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <i>METRO CREMATORY</i> | | 20c. LOCATION — City or Town, State <i>7/5/95 BALTIMORE, MD.</i> | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Larry D. Reese</i> | | 22. NAME AND ADDRESS OF FACILITY <i>REESE & SONS MORTUARY, P.A. 821 WESTT ST. ANNAPOLIS, MD. 21401</i> | | 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>a. Pulmonary Embolus</i> DUE TO (OR AS A CONSEQUENCE OF): <i>b. Polycythemia Vera</i> DUE TO (OR AS A CONSEQUENCE OF): <i>c.</i> DUE TO (OR AS A CONSEQUENCE OF): <i>d.</i> Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | Approximate interval Between Onset and Death <i>Feb 95</i> <i>1991</i> | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | 24a. WAS AN AUTOPSY PERFORMED? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | |
| 27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | 29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER <i>Rochelle M. Cunningham M.D.</i> | | 29c. LICENSE NUMBER <i>07770</i> | | 29d. DATE SIGNED (Month, Day, Year) <i>7/1/95</i> | | 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (Item 27) (Type, Print) <i>Rochelle Cunningham University Hospital Balt, Md</i> | |
| 31. DATE FILED (Month, Day, Year) <i>JUL 10 1995</i> | | 32. REGISTRAR'S SIGNATURE <i>Juli Anderson-Randall</i> | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.


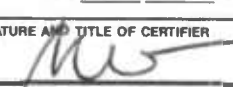
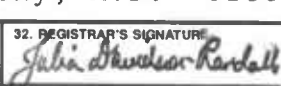
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 21843

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) VIVIAN N. LYLE | | | | 2. DATE OF DEATH MONTH JULY DAY 5 YEAR 1995 | | 3. TIME OF DEATH 12:50 P M | |
| 4. SOCIAL SECURITY NUMBER 577-58-6469 | | 5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 87 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) April 11, 1908 Missouri | |
| 9a. FACILITY NAME (If not institution, give street and number) Southern Maryland Hospital | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Clinton | | 9c. COUNTY OF DEATH Prince George's | |
| 10a. STATE Maryland | | 10b. COUNTY Prince George's | | 10c. CITY, TOWN OR LOCATION Fort Washington | | 10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 10e. STREET AND NUMBER 7927 Allentown Road | | | | 10f. ZIP CODE 20744 | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: Caucasian | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4 or 5+) <input type="checkbox"/> | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Secretary | | 16b. KIND OF BUSINESS/INDUSTRY Internal Revenue Service | | | |
| 17. FATHER'S NAME (First, Middle, Last) Otto K. Neihardt | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Lottie Craig | | | |
| 19a. INFORMANT'S NAME (Type/Print) Paul L. Lyle | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7927 Allentown Road Ft. Washington Md 20744 | | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Cedar Hill Cemetery July 7, 1995 | | 20c. LOCATION — City or Town, State Suitland Maryland | | 22. NAME AND ADDRESS OF FACILITY Lee Funeral Home, Inc 6633 Old Alex. Ferry Rd., Clinton, Md. | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE  | | | | | | | |
| 23. PART I. Enter the diseases, or complications, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Colorectal cancer DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Approximate Interval Between Onset and Death: months | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Congestive heart failure | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| 29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER  | | | | 29c. LICENSE NUMBER D-18545 | | 29d. DATE SIGNED (Month, Day, Year) July 5, 1995 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Philip Wisotsky, M.D. 6188 Oxon Hill Rd, # 601, OxonHill, MD 20745 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JUL 11 1995 | | | | 32. REGISTRAR'S SIGNATURE  | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 21844

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|---|--|--|--------------------------------|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) Juanita Virginia Lidke | | | | 2. DATE OF DEATH MONTH July DAY 08 YEAR 1995 | | 3. TIME OF DEATH 12:15 P M | |
| 4. SOCIAL SECURITY NUMBER 212-80-1925 | | 5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F | 6. AGE (In yrs. last birthday) 31 YRS. | IF UNDER 1 YEAR MONTHS DAYS | IF UNDER 24 HRS. HOURS MIN. | 7. DATE OF BIRTH (Month, Day, Year) Aug. 6, 1963 | |
| 8. BIRTHPLACE (State or Foreign Country) Maryland | | | | 9a. FACILITY NAME (If not institution, give street and number) 314 Alliance Street | | 9b. CITY, TOWN OR LOCATION OF DEATH Havre de Grace | |
| 9c. COUNTY OF DEATH Harford | | | | 10a. STATE Maryland | | 10b. COUNTY Harford | |
| 10c. CITY, TOWN OR LOCATION Havre de Grace | | | | 10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | 10e. STREET AND NUMBER 314 Alliance Street | |
| 10f. ZIP CODE 21078 | | | | 10g. CITIZEN OF WHAT COUNTRY? USA | | 11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 6+) College | | | | 15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Homemaker | | 15b. KIND OF BUSINESS/INDUSTRY Private Home | |
| 17. FATHER'S NAME (First, Middle, Last) John Morris Wilkie, Sr. | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Janet Harvey | | | |
| 19a. INFORMANT'S NAME (Type/Print) Mr. Jeffery Ray Lidke | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 314 Alliance Street, Havre de Grace, MD 21078 | | | |
| 20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) R.A. Ferris & Co., Inc. 7/12 | | 20c. LOCATION — City or Town, State West Chester, PA | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Madelyn Mitchell Shant | | | | 22. NAME AND ADDRESS OF FACILITY Mitchell-Smith Funeral Home, P.A. Havre de Grace, MD 21078 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Cervical cancer DUE TO (OR AS A CONSEQUENCE OF): a. Cervical cancer b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): Approximate Interval Between Onset and Death 1 year | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M <input type="checkbox"/> YES <input type="checkbox"/> NO | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | 29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER J. Bellantoni MD | | | | 29c. LICENSE NUMBER D 33079 | | 29d. DATE SIGNED (Month, Day, Year) 7/10/95 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) J. BELLANTONI 607 S. UNION AVE, HAVRE DE GRACE, MD 21078 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JUL 11 1995 | | | | 32. REGISTRAR'S SIGNATURE John Andrew Randall | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 687600

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 21845

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|---|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) Norman Lester Lee | | | | 2. DATE OF DEATH MONTH DAY YEAR July 1, 1995 | | 3. TIME OF DEATH 2010 M | |
| 4. SOCIAL SECURITY NUMBER 217-22-1314 | | 5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 68 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) July 17, 1926 | |
| 8. BIRTHPLACE (State or Foreign Country) Maryland | | 9a. FACILITY NAME (If not institution, give street and number) Medpointe | | 9b. CITY, TOWN OR LOCATION OF DEATH Elkton | | 9c. COUNTY OF DEATH Cecil | |
| 10a. STATE Delaware | | | | 10b. COUNTY New Castle | | 10c. CITY, TOWN OR LOCATION Newark | |
| 10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | 10e. STREET AND NUMBER 130 East Park Place | | | |
| 10f. ZIP CODE 19711 | | | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | | | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 9 | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Electric Punch Operator | | 16b. KIND OF BUSINESS/INDUSTRY National Vulcanized Fibers | | | |
| 17. FATHER'S NAME (First, Middle, Last) Charles R. Lee | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Jane Little | | | |
| 19a. INFORMANT'S NAME (Type/Print) Sophie Lee | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 130 East Park Place - Newark, DE 19711 | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) Union Cemetery | | 20c. LOCATION — City or Town, State 7-5 1995 Union, Maryland | | 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Donna S. Hicks</i> | |
| 22. NAME AND ADDRESS OF FACILITY Hicks Home for Funerals, P.A. 103 West Stockton Street Elkton, MD 21921-5521 | | 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <u>AUTOIMMUNE DEFICIENCY SYNDROME</u> DUE TO (OR AS A CONSEQUENCE OF): b. <u>HEPATITIS B</u> DUE TO (OR AS A CONSEQUENCE OF): c. <u>OLD CVA WITH HEMIPARESIS</u> DUE TO (OR AS A CONSEQUENCE OF): d. <u>ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</u> Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | |
| 27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER <i>Julia Driscoll-Randall</i> | | | | 29c. LICENSE NUMBER 017863 | | 29d. DATE SIGNED (Month, Day, Year) 7/1/95 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Rolando A. Najera, M.D. - 118 North Street - Elkton, MD 21921 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JUL 06 1995 | | | | 32. REGISTRAR'S SIGNATURE <i>Julia Driscoll-Randall</i> | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 21846

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|--|--|---|--|---|--|
| 1. DECEASED'S NAME (First, Middle, Last) Robert Lee Larrimore | | | | 2. DATE OF DEATH MONTH DAY YEAR June 18 1995 | | 3. TIME OF DEATH M 0550 | |
| 4. SOCIAL SECURITY NUMBER 218-05-3015 | | 5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 75 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) September 28, 1919 Maryland | |
| 9a. FACILITY NAME (If not institution, give street and number) Kent & Queen Anne's Hospital, Inc., | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Chestertown Maryland | | 9c. COUNTY OF DEATH Kent | |
| 10a. STATE Maryland | | 10b. COUNTY Kent | | 10c. CITY, TOWN OR LOCATION Rock Hall | | 10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 10e. STREET AND NUMBER Main Street - Post Office Box 351 | | | | 10f. ZIP CODE 21661 | | 10g. CITIZEN OF WHAT COUNTRY? United States | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES World War II | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No - If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE - American Indian, Black, White, etc. Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 10 College (1-4 or 5+) Waterman | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Waterman | | 16b. KIND OF BUSINESS/INDUSTRY Tug Boat Captain | | | |
| 17. FATHER'S NAME (First, Middle, Last) William Roland Larrimore | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Barbara Frost | | | |
| 19a. INFORMANT'S NAME (Type/Print) Clay Larrimore | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 305 Campus Avenue, Chestertown, Maryland 21620 | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Wesley Cemetery - June 22, 1995 | | 20c. LOCATION - City or Town, State Rock Hall, Maryland | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE William L. King Jr. | | | | 22. NAME AND ADDRESS OF FACILITY Fellows - Wells Funeral Home Maryland Route 20, Rock Hall, Maryland 21661 | | | |
| 23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Respiratory Failure Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. Coronary Heart Failure c. Renal Failure | | | | | | | Approximate Interval Between Onset and Death |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Hypertension, Obesity, Hyperkalemia, DTD CS Spinal Stenosis & Surgery, Occlusion of peripheral artery | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | | | | DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/> |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) None | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 28d. DESCRIBE NOW INJURY OCCURRED | | | | 28e. PLACE OF INJURY - At home, farm, street, factory, office building, etc. (Specify) | | | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER Charles M. King | | | | 29c. LICENSE NUMBER 123889 | | 29d. DATE SIGNED (Month, Day, Year) 6/20/95 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) John C. Anderson, MD, 948 Washington Ave, Chestertown Md, 21620 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JUN 22 '95 | | 32. REGISTRAR'S SIGNATURE John Davidson-Randall | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 21847

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) CAROLYN M. LOMAX | | | | 2. DATE OF DEATH MONTH 6 DAY 6 YEAR 1995 | | 3. TIME OF DEATH 4:00 AM | |
| 4. SOCIAL SECURITY NUMBER 216148971 | | 5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 74 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 5-19-1921 | |
| 8. BIRTHPLACE (State or Foreign Country) MD. | | | | 9a. FACILITY NAME (If not institution, give street and number) CHESTER TOWN NURSING CENTER | | 9b. CITY, TOWN OR LOCATION OF DEATH CHESTER TOWN | |
| 9c. COUNTY OF DEATH KENT | | | | 10a. STATE MD | | | |
| 10b. COUNTY KENT | | 10c. CITY, TOWN OR LOCATION CHESTER TOWN | | 10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | 10e. STREET AND NUMBER 224 FRONT ST. | |
| 10f. ZIP CODE 21620 | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A | | 11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | |
| 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: BLACK | | 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 0-11 College (1-4 or 5+) College | | 16. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) HOUSEWIFE | |
| 16b. KIND OF BUSINESS/INDUSTRY HOME | | 17. FATHER'S NAME (First, Middle, Last) DAVID MILLER | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) LULA | | 19a. INFORMANT'S NAME (Type/Print) GEORGE A. LOMAX | |
| 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 224 FRONT ST. CHESTER TOWN MD | | 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) EMMANUEL 6/13/95 CHESTER TOWN MD | | 20c. LOCATION — City or Town, State | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Dennette Walker | | 22. NAME AND ADDRESS OF FACILITY WALKER FUNERAL HOME CHESTER TOWN, MD | | 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. ALZHEIMER'S DEMENTIA DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | Approximate Interval Between Onset and Death 10 YRS | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | |
| 26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | |
| 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. SIGNATURE AND TITLE OF CERTIFIER John C. Seymour | | 29c. LICENSE NUMBER 12-13824 | | 29d. DATE SIGNED (Month, Day, Year) 6-9-95 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) John C. Seymour 122 SPEER RD. CHESTER TOWN MD. | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JUN 15 '95 | | 32. REGISTRAR'S SIGNATURE John Davidson-Randall | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.


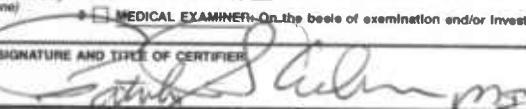
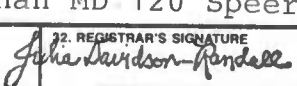
Amended # 4 6-8-95, JAK, Kent County
Amended #4: 6/07/95, B.A.G., Kent County

95 21848

FOR
STATE
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | |
|---|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) Louis James Lingerman | | 2. DATE OF DEATH MONTH DAY YEAR May 31 1995 | | 3. TIME OF DEATH M 10:28AM | |
| 2. SOCIAL SECURITY NUMBER 217-38-1561 | | 5. SEX 1 <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 55 YRS. | |
| 7. DATE OF BIRTH (Month, Day, Year) Sept 19, 1939 | | 8. BIRTHPLACE (State or Foreign Country) Maryland | | | |
| 9a. FACILITY NAME (If not institution, give street and number) 9204 Queen Anne | | 9b. CITY, TOWN OR LOCATION OF DEATH Chestertown | | 9c. COUNTY OF DEATH Kent | |
| 10a. STATE Maryland | | 10b. COUNTY Kent | | 10c. CITY, TOWN OR LOCATION Chestertown | |
| 10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 10e. STREET AND NUMBER 9204 Queen Anne | | 10f. ZIP CODE 21620 | |
| 10g. CITIZEN OF WHAT COUNTRY? USA | | 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | |
| 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White | | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) 11 Elementary/Secondary (9-12) College (1-4 or 5+) | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Bar Owner | | 16b. KIND OF BUSINESS/INDUSTRY Bar/Tavern Service | |
| 17. FATHER'S NAME (First, Middle, Last) George Lingerman | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Lovetta Kuhn Lingerman | | | |
| 19a. INFORMANT'S NAME (Type/Print) Jacklyn Lingerman | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9204 Queen Ann Chestertown, MD 21620 | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) St. Pauls Cemetery 6/3 | | 20c. LOCATION — City or Town, State Chestertown, MD | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE  | | 22. NAME AND ADDRESS OF FACILITY Helfenbein Funeral Home 130 Speer Road Chestertown Md. 21620 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. METASTATIC PROSTATE CA. DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. | | Approximate Interval Between Onset and Death 2 yrs. | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. alone | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) N/A | | 28b. TIME OF INJURY M | |
| 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. CERTIFIER 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. SIGNATURE AND TITLE OF CERTIFIER  | | 29c. LICENSE NUMBER D36054 | |
| 29d. DATE SIGNED (Month, Day, Year) 6/1/95 | | 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Patrick Shanahan MD 120 Speer Rd. Chestertown, MD. 21620 | | | |
| 31. DATE FILED (Month, Day, Year) JUN 02 '95 | | 32. REGISTRAR'S SIGNATURE  | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 21849

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|---|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) <i>JUNE MYERS</i> | | | | 2. DATE OF DEATH MONTH <i>7</i> DAY <i>5</i> YEAR <i>95</i> | | 3. TIME OF DEATH <i>7:40 PM</i> | |
| 4. SOCIAL SECURITY NUMBER <i>220-16-8056</i> | | 5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) <i>70</i> YRS. | | 7. DATE OF BIRTH (Month, Day, Year) <i>6/2/25</i> | |
| 9a. FACILITY NAME (If not institution, give street and number) <i>Anne Arundel Medical Center</i> | | | | 9b. CITY, TOWN OR LOCATION OF DEATH <i>Annapolis</i> | | 9c. COUNTY OF DEATH <i>Anne Arundel</i> | |
| 10a. STATE <i>MD</i> | | | | 10b. COUNTY <i>Anne Arundel</i> | | 10c. CITY, TOWN OR LOCATION <i>Annapolis</i> | |
| 10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | | | | | | |
| 10e. STREET AND NUMBER <i>412 Ludlow Road</i> | | | | 10f. ZIP CODE <i>21401</i> | | 10g. CITIZEN OF WHAT COUNTRY? <i>United States</i> | |
| 11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: <i>White</i> | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <i>12</i> College (1-4 or 5+) <i></i> | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <i>Homemaker</i> | | 16b. KIND OF BUSINESS/INDUSTRY <i>Home</i> | | | |
| 17. FATHER'S NAME (First, Middle, Last) <i>Frederick Merriken</i> | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) <i>Hazel L. Lark</i> | | | |
| 19a. INFORMANT'S NAME (Type/Print) <i>Barry Myers</i> | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>412 Ludlow Road Annapolis, Maryland 21401</i> | | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <i>Hillcrest Cemetery 7/7/95</i> | | 20c. LOCATION — City or Town, State <i>Annapolis, Maryland</i> | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Donald S. Lytle</i> | | | | 22. NAME AND ADDRESS OF FACILITY <i>John M. Taylor Funeral Home 147 Duke of Gloucester St. Annapolis, MD</i> | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>congestive Heart failure</i> | | | | | | | |
| Approximate Interval Between Onset and Death <i>10 years</i> | | | | | | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | | |
| b. <i>coronary artery disease</i> | | | | | | | |
| Approximate Interval Between Onset and Death <i>10 years</i> | | | | | | | |
| c. <i></i> | | | | | | | |
| d. <i></i> | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>insulin dependent diabetes</i> | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY <i>M</i> | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER <i>Stuart E. Selouch, MD</i> | | | | 29c. LICENSE NUMBER <i>D019838</i> | | 29d. DATE SIGNED (Month, Day, Year) <i>July 5, 1995</i> | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>Stuart E. Selouch, MD 400 Bestgate Rd. Annapolis, Md. 21404</i> | | | | | | | |
| 31. DATE FILED (Month, Day, Year) <i>JUL 10 1995</i> | | 32. REGISTRAR'S SIGNATURE <i>Gabe Andrew Randall</i> | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 21850

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|---|--|--|--|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last) Kenneth L. Mink Sr, | | | | 2. DATE OF DEATH MONTH DAY YEAR July 8 1995 | | 3. TIME OF DEATH 07:55 A.M. | |
| 4. SOCIAL SECURITY NUMBER 198-10-1810 | | 5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 75 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) Oct. 1, 1919 | |
| 8. BIRTHPLACE (State or Foreign Country) Pennsylvania | | 9a. FACILITY NAME (If not institution, give street and number) 65 Kent Avenue | | 9b. CITY, TOWN OR LOCATION OF DEATH Earleville | | 9c. COUNTY OF DEATH Cecil | |
| RESIDENCE OF DECEDENT | | | | | | | |
| 10a. STATE Pennsylvania | | 10b. COUNTY Delaware | | 10c. CITY, TOWN OR LOCATION Newtown Square | | 10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 10e. STREET AND NUMBER 1010 Pritchard Place | | | | 10f. ZIP CODE 19073 | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES World War II | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) | | 15b. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Sales/Lease | | 16b. KIND OF BUSINESS/INDUSTRY Oriental Rug | | | |
| 17. FATHER'S NAME (First, Middle, Last) John Mink | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Mabel Fox | | | |
| 19a. INFORMANT'S NAME (Type/Print) Grace Mink | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1010 Pritchard Place - Newtown Square, PA 19073 | | | |
| 20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) West Laurel Hill Crematory 1995 | | 20c. LOCATION — City or Town, State Bala Cynwyd, PA | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Donald S. Hicks</i> | | | | 22. NAME AND ADDRESS OF FACILITY Hicks Home for Funerals, P.A. 103 W. Stockton St., Elkton, MD. 21921 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Lymphoma DUE TO (OR AS A CONSEQUENCE OF): Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST b. Anemia DUE TO (OR AS A CONSEQUENCE OF): c. neutropenia DUE TO (OR AS A CONSEQUENCE OF): d. | | | | | | | Approximate Interval Between Onset and Death |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | | | | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | |
| 27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 6 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER <i>Jose Ma, M.D.</i> | | | | 29c. LICENSE NUMBER 044716 | | 29d. DATE SIGNED (Month, Day, Year) 7/8/95 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Jose Ma, M.D. 111 W. High St., Elkton, MD. 21921 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JUL 10 1995 | | | | 32. REGISTRAR'S SIGNATURE <i>John D. ...</i> | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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95 21851

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|---|--|---|--|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last) LILLIAN N. MCFARLANE | | | | 2. DATE OF DEATH MONTH JULY DAY 05 YEAR 1995 | | 3. TIME OF DEATH 1656 P M | |
| 4. SOCIAL SECURITY NUMBER 233 10 6621 | | 5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 78 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) Dec. 23, 1916 | |
| 9a. FACILITY NAME (If not institution, give street and number) MEMORIAL HOSPITAL | | | | 9b. CITY, TOWN OR LOCATION OF DEATH CUMBERLAND | | 9c. COUNTY OF DEATH ALLEGANY | |
| RESIDENCE OF DECEDENT | | | | | | | |
| 10a. STATE MARYLAND | | 10b. COUNTY ALLEGANY | | 10c. CITY, TOWN OR LOCATION CUMBERLAND | | 10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | |
| 10e. STREET AND NUMBER 116 GREENE STREET | | | | 10f. ZIP CODE 21502 | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: WHITE | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 2 College (1-4 or 5+) | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) BEAUTICIAN | | 16b. KIND OF BUSINESS/INDUSTRY BEAUTY SALON | | | |
| 17. FATHER'S NAME (First, Middle, Last) DAVID MCFARLANE | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) EDITH PENDLEBURY | | | |
| 19a. INFORMANT'S NAME (Type/Print) CAROLE JEAN NICOL | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2310 DUNKIRK DR.-OWINGS, MD 20736 | | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) OAK HILL CEMETERY 7/8/95 | | 20c. LOCATION — City or Town, State LONACONING, MD | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>George Upchurch</i> | | | | 22. NAME AND ADDRESS OF FACILITY GEORGE-UPCHURCH FUNERAL HOME, P.A. 202 GREENE ST., CUMBERLAND, MD 21502 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Coronary Artery Disease DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. | | | | | | | Approximate Interval Between Onset and Death 6 years |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Diabetes Mellitus | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO | | | | | | | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| 29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER <i>Sunil Gupta</i> | | | | 29c. LICENSE NUMBER D33280 | | 29d. DATE SIGNED (Month, Day, Year) July 6, 1995 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) DR SUNIL GUPTA 625 KENT AVE., CUMBERLAND, MD 21502 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JUL 07 1995 | | | | 32. REGISTRAR'S SIGNATURE <i>John Anderson-Randall</i> | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 21852

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) VANESSA LOUISE MONGOLD | | | | 2. DATE OF DEATH MONTH DAY YEAR July 1, 1995 | | 3. TIME OF DEATH 8:37 A M | |
| 4. SOCIAL SECURITY NUMBER 216-66-0180 | | 5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 40 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) June 29, 1955 | |
| 8. BIRTHPLACE (State or Foreign Country) West Virginia | | | | 9a. FACILITY NAME (If not institution, give street and number) Memorial Hospital | | 9b. CITY, TOWN OR LOCATION OF DEATH Cumberland | |
| 9c. COUNTY OF DEATH Allegany | | | | 10a. STATE MARYLAND | | 10b. COUNTY ALLEGANY | |
| 10c. CITY, TOWN OR LOCATION CUMBERLAND | | | | 10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 10e. STREET AND NUMBER 13311 JADE STREET | |
| 10f. ZIP CODE 21502 | | | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | | 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: WHITE | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) UNKNOWN College (14 or 5+) College | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) HOMEMAKER | | 16b. KIND OF BUSINESS/INDUSTRY HOME | |
| 17. FATHER'S NAME (First, Middle, Last) UNKNOWN | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) GERALDINE KERNS | | | |
| 19a. INFORMANT'S NAME (Type/Print) BILLY MONGOLD | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13311 JADE ST., CUMBERLAND, MD 21502 | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) DAVIS MEML. CEMETERY 7/3/95 | | 20c. LOCATION — City or Town, State CUMBERLAND, MD | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Kendy G. Upchurch</i> | | | | 22. NAME AND ADDRESS OF FACILITY GEORGE-UPCHURCH FUNERAL HOME, P.A. 202 GREENE ST., CUMBERLAND, MD 21502 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | | | | | | | |
| a. ADVANCED CARCINOMA BREAST DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| b. INTRACTABLE PAIN DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| c. DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| d. DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | | | | |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | | | | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify) | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 6 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide | | | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | |
| 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | 28d. DESCRIBE NOW INJURY OCCURED | | | |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER <i>Dr. Q. Zaman</i> | | | | 29c. LICENSE NUMBER D 23371 | | 29d. DATE SIGNED (Month, Day, Year) July 3, 95 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Dr. Q. Zaman Johnson Heights Medical Bldg. Cumberland, MD 21502 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JUL 05 1995 | | | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 21853

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) MARY E. MELVIN | | | | 2. DATE OF DEATH MONTH JUNE DAY 18 YEAR 1995 | | 3. TIME OF DEATH 1:30 A M | |
| 4. SOCIAL SECURITY NUMBER 208-20-2467 | | 5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 86 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) Oct. 31, 1908 | |
| 8. BIRTHPLACE (State or Foreign Country) Pennsylvania | | | | 9a. FACILITY NAME (If not institution, give street and number) AT HOME 304 Princess Anne Drive | | 9b. CITY, TOWN OR LOCATION OF DEATH CHESTERTOWN | |
| 9c. COUNTY OF DEATH QUEEN ANNES | | | | 10a. STATE Maryland | | 10b. COUNTY QUEEN ANNES | |
| 10c. CITY, TOWN OR LOCATION CHESTERTOWN, | | | | 10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 10e. STREET AND NUMBER 304 PRINCESS ANNE DRIVE | |
| 10f. ZIP CODE 21620 | | | | 10g. CITIZEN OF WHAT COUNTRY? USA | | 11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: WHITE | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 9 College (1-4 or 5+) | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) HOMEMAKER | | 16b. KIND OF BUSINESS/INDUSTRY HOME | |
| 17. FATHER'S NAME (First, Middle, Last) EMORY E. PHILLIPS | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) MARGARET WATERSON | | | |
| 19a. INFORMANT'S NAME (Type/Print) MAXINE STEWART | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 304 Princess Anne, Dr. Chestertown, Md. 21620 | | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) SYLVANIA HILLS CEMETERY | | 20c. LOCATION — City or Town, State ROCHESTER, PA. | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Mary B. Fellows</i> | | | | 22. NAME AND ADDRESS OF FACILITY FELLOWS - WELLS FUNERAL HOME 413 HIGH ST. CHESTERTOWN, MD. 21620 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → CHF 2° CAD Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST COPD Approximate Interval Between Onset and Death 1 yr. 5 yr. | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. N/A | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) N/A | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 28a. PLACE OF INJURY — At home, term, street, factory, office building, etc. (Specify) | | 28d. DESCRIBE HOW INJURY OCCURRED | | | | | |
| 28e. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | |
| 29a. CERTIFIER <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER <i>Patrick Shanahan M.D.</i> | | | | 29c. LICENSE NUMBER D36054 | | 29d. DATE SIGNED (Month, Day, Year) 6/18/95 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 120 SPEEN Rd CHESTERTOWN Md suite 2 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JUN 20 '95 | | | | 32. REGISTRAR'S SIGNATURE <i>Galia Davidson-Randall</i> | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 21854

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|--|--|---|--|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last) WILLIAM MYERS McLEER | | | | 2. DATE OF DEATH MONTH JULY DAY 1 YEAR 1995 | | 3. TIME OF DEATH 1:45 P M | |
| 4. SOCIAL SECURITY NUMBER 099-14-3364 | | 5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 71 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) SEPT. 23, 1923 | |
| 9a. FACILITY NAME (If not institution, give street and number) 7769 COUNTRY CLUB LANE | | | | 9b. CITY, TOWN OR LOCATION OF DEATH CHESTERTOWN | | 9c. COUNTY OF DEATH KENT | |
| RESIDENCE OF DECEDENT | | | | | | | |
| 10a. STATE MARYLAND | | 10b. COUNTY KENT | | 10c. CITY, TOWN OR LOCATION CHESTERTOWN | | 10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 10e. STREET AND NUMBER 7769 COUNTRY CLUB LANE | | | | 10f. ZIP CODE 21620 | | 10g. CITIZEN OF WHAT COUNTRY? UNITED STATES | |
| 11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES WWII & KOREA | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: WHITE | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 6 College (1-4 or 5+) 6 | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) FOOD IMPORTS, PRESIDENT | | 16b. KIND OF BUSINESS/INDUSTRY IMPORTING | | | |
| 17. FATHER'S NAME (First, Middle, Last) WILLIAM HERBERT McLEER | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) DOROTHY FLEMING MYERS | | | |
| 19a. INFORMANT'S NAME (Type/Print) UNA LEE McLEER | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7769 COUNTRY CLUB LANE, CHESTERTOWN, MD. 21620 | | | |
| 20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) CAPITAL CREMATORY, JULY 2, 1995 | | 20c. LOCATION — City or Town, State DOVER, DE. | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Day B. Fellows</i> | | | | 22. NAME AND ADDRESS OF FACILITY FELLOWS - WELLS FUNERAL HOME 413 HIGH ST. CHESTERTOWN, MD. 21620 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Severe Chronic Pulmonary Disease 5 year DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. | | | | | | | Approximate interval Between Onset and Death |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Coronary Artery Disease & prior Myocardial Disease DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| 29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER <i>George M. Young</i> | | | | 29c. LICENSE NUMBER D 31979 | | 29d. DATE SIGNED (Month, Day, Year) 7/1/95 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) GEORGE M. YOUNG Kent + QUEEN ANNE'S MD 21620 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JUL 06 '95 | | | | 32. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i> | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 21855

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) George Kenneth Miller Sr. | | | | 2. DATE OF DEATH MONTH DAY YEAR June 8, 1995 | | 3. TIME OF DEATH 2235 M | |
| 4. SOCIAL SECURITY NUMBER 220-05-1059 | | 5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 84 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) December 23, 1909 | |
| 8. BIRTHPLACE (State or Foreign Country) Maryland | | | | 9a. FACILITY NAME (If not Institution, give street and number) Kent & Queen Anne's County Hospital | | 9b. CITY, TOWN OR LOCATION OF DEATH Chestertown | |
| 9c. COUNTY OF DEATH Kent | | | | 10a. STATE Maryland | | 10b. COUNTY Kent | |
| 10c. CITY, TOWN OR LOCATION Betterton | | | | 10d. INSIDE CITY LIMITS? XX YES 2 <input type="checkbox"/> NO | | 10e. STREET AND NUMBER 206 Church Lane | |
| 10f. ZIP CODE 21610 | | | | 10g. CITIZEN OF WHAT COUNTRY? United States | | 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 2 | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Draftsman / Engineer | | 16b. KIND OF BUSINESS/INDUSTRY Engineering | |
| 17. FATHER'S NAME (First, Middle, Last) George W. Miller | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Mary Rigney | | | |
| 19a. INFORMANT'S NAME (Type/Print) Mrs. Mabel L. Miller | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 206 Church Lane, Betterton, Maryland 21610 | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 8 <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Poplar Grove - June 13, 1995 | | 20c. LOCATION — City or Town, State Phoenixville, Maryland | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE William L. King Jr. | | | | 22. NAME AND ADDRESS OF FACILITY Fellows - Wells Funeral Home 413 West High Street, Chestertown, Maryland | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <u>Respiratory Failure</u> DUE TO (OR AS A CONSEQUENCE OF): b. <u>Renal Failure</u> DUE TO (OR AS A CONSEQUENCE OF): c. <u>ASCVD</u> DUE TO (OR AS A CONSEQUENCE OF): d. Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>HTN, Dysrhythmia, Bradycardia, CHF</u> <u>Severe PVD, Torticollis and Elbow Artery</u> DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide 3 <input type="checkbox"/> Homicide 8 <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) <u>None</u> | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER <u>Charles MD</u> | | | | 29c. LICENSE NUMBER <u>023889</u> | | 29d. DATE SIGNED (Month, Day, Year) ▶ | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <u>988 W. Ashworth Ave, Chestertown Md 21620</u> | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JUN 13 95 | | | | 32. REGISTRAR'S SIGNATURE <u>John Davidson-Randall</u> | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 21856

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|---|--|---|--|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last) RICHARD Thomas MATTHEWS | | | | 2. DATE OF DEATH MONTH JULY DAY 12 YEAR 1995 | | 3. TIME OF DEATH 10:31P M | |
| 4. SOCIAL SECURITY NUMBER 232-04-6692 | | 5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 26 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 4/18/1969 | |
| 9a. FACILITY NAME (If not institution, give street and number) WASHINGTON COUNTY HOSPITAL | | | | 9b. CITY, TOWN OR LOCATION OF DEATH HAGERSTOWN | | 9c. COUNTY OF DEATH WASHINGTON | |
| 10a. STATE W.V. | | 10b. COUNTY Jefferson | | 10c. CITY, TOWN OR LOCATION Shenandoah Junction | | 10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 10e. STREET AND NUMBER P.O.Box 234 | | | | 10f. ZIP CODE 25442 | | 10g. CITIZEN OF WHAT COUNTRY? USA | |
| 11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: white | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 9th College (13-16 or 17+) College | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) iron worker | | 16b. KIND OF BUSINESS/INDUSTRY construction | | | |
| 17. FATHER'S NAME (First, Middle, Last) Everett Matthews | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Pauline Foley | | | |
| 19a. INFORMANT'S NAME (Type/Print) Twila Matthews | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) P.O.Box 234 Shenandoah Junction, WV 25442 | | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematorium, or other place) Rosedale Cemetery 7/18/95 | | 20c. LOCATION — City or Town, State Martinsburg, WV | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Diabla Berthiaume</i> | | | | 22. NAME AND ADDRESS OF FACILITY Rosedale Funeral Chapel, Inc 2060 Rosedale Rd., Mtsbg, WV 25401 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Multiple Injuries DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | | Approximate Interval Between Onset and Death |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | | | | | | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) 7/12/95 | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | |
| | | 28d. DESCRIBE HOW INJURY OCCURRED subject fell and grasped electrical wire | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) work site | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) 500 Eastern Boulevard Hagerstown, Maryland | |
| 29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER <i>Theodore M. King</i> | | | | 29c. LICENSE NUMBER O.C.M.E. | | 29d. DATE SIGNED (Month, Day, Year) JULY 13, 1995 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) THEODORE M. KING 111 Penn Street, Baltimore, Maryland 21201 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JUL 19 1995 | | | | 32. REGISTRAR'S SIGNATURE <i>John Buckner Randall</i> | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

P.O. BOX 68760

DIVISION OF VITAL RECORDS

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) DONALD R. MILLER | | | | 2. DATE OF DEATH MONTH DAY YEAR JUNE 25 1995 | | 3. TIME OF DEATH 5:05 A M | |
| 4. SOCIAL SECURITY NUMBER 150-32-1364 | | 5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 53 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) Apr. 19, 1942 | |
| 8. BIRTHPLACE (State or Foreign Country) Harrisburg, PA | | | | 9a. FACILITY NAME (If not institution, give street and number) MARYLAND SHOCK TRAUMA | | 9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE CITY | |
| 9c. COUNTY OF DEATH Baltimore | | | | 10a. STATE PA | | 10b. COUNTY Lancaster | |
| 10c. CITY, TOWN OR LOCATION Lititz | | | | 10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 10e. STREET AND NUMBER 421 Arrowhead Dr. | |
| 10f. ZIP CODE 17543 | | | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | | 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Owner/Operator | | 16b. KIND OF BUSINESS/INDUSTRY Bakery | |
| 17. FATHER'S NAME (First, Middle, Last) David E. Miller | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Susanna Rutt | | | |
| 19a. INFORMANT'S NAME (Type/Print) Barbara Miller | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 421 Arrowhead Dr., Lititz, PA 17543 | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Millersville Mennonite Cem 6/29/95 | | 20c. LOCATION — City or Town, State Millersville, PA | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>John B. Thomas 0048</i> | | | | 22. NAME AND ADDRESS OF FACILITY Fred F. Groff, Inc. 234 W. Orange St., Lancaster, PA 17603 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <i>Head Injuries</i> DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input checked="" type="checkbox"/> Accident 8 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) 6-24-95 | | 28b. TIME OF INJURY 1745 M | | 28c. INJURY AT WORK? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED <i>Subject fell off ladder</i> | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) <i>Roadway</i> | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) <i>FL Smallowood Rd Pasadena</i> | | | |
| 29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i> | | | | 29c. LICENSE NUMBER O.C.M.E | | 29d. DATE SIGNED (Month, Day, Year) JUNE 25, 1995 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>David R Fowler</i> 111 Penn Street, Baltimore, Maryland 21201 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JUL 18 1995 | | | | 32. REGISTRAR'S SIGNATURE <i>John D. [Signature]</i> | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

BALTIMORE, MARYLAND 21215-0020

BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 21858

Amended #28a, 7/7/95, M.D.S., Allegany Co.

FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|---|--|--|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) RICHARD E. NELSON | | | | 2. DATE OF DEATH MONTH DAY YEAR JULY 1, 1995 | | 3. TIME OF DEATH 11:42 A. M | |
| 4. SOCIAL SECURITY NUMBER 218-30-0443 | | 5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 62 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) Mar 24, 1933 | |
| 9a. FACILITY NAME (If not institution, give street and number) 12523 MCMULLEN HIGHWAY | | | | 9b. CITY, TOWN OR LOCATION OF DEATH CUMBERLAND | | 9c. COUNTY OF DEATH ALLEGANY | |
| RESIDENCE OF DECEDENT | | | | | | | |
| 10a. STATE MD | | 10b. COUNTY Allegany | | 10c. CITY, TOWN OR LOCATION Cumberland | | 10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 10e. STREET AND NUMBER 12523 McMullen Highway | | | | 10f. ZIP CODE 21502 | | 10g. CITIZEN OF WHAT COUNTRY? USA | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES 1953-1956 | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: white | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 12 | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) ret. superintendent | | 16b. KIND OF BUSINESS/INDUSTRY State of MD | |
| 17. FATHER'S NAME (First, Middle, Last) George O. Nelson | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Pauline R. Ullery | | | |
| 19a. INFORMANT'S NAME (Type/Print) Reba M. Nelson | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12523 McMullen Highway; Cumberland, MD 21502 | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Rocky Gap Veterans Cem | | DATE 07/05 | | 20c. LOCATION — City or Town, State Flintstone, MD | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE James F. Scarpelli | | | | 22. NAME AND ADDRESS OF FACILITY Scarpelli Funeral Home Cumberland, MD 21502 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | | | | | | | |
| a. <u>Cerebrovascular accident</u> DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| b. <u>peripheral vascular disease</u> DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| c. <u>hypertension</u> DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| d. <u>coronary artery disease</u> | | | | | | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? RELEASED 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) 7/1/95 | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | | | 28e. PLACE OR INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| 29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER J. Poonai | | | | 29c. LICENSE NUMBER D36766 | | 29d. DATE SIGNED (Month, Day, Year) July 3, 1995 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) V. Poonai, M.D.; 955 Frederick Street; Cumberland, MD 21502 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JUL 07 1995 | | | | 32. REGISTRAR'S SIGNATURE John Davidson | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

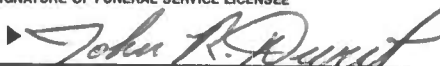
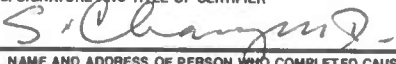

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 21859

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) VINCENT DANIEL NOLAN | | | | 2. DATE OF DEATH MONTH JULY DAY 3 YEAR 1995 | | 3. TIME OF DEATH 06:00A^M | |
| 4. SOCIAL SECURITY NUMBER 214-14-7935 | | 5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 75 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) August 15, 1919 | |
| 8. BIRTHPLACE (State or Foreign Country) Maryland | | | | 9a. FACILITY NAME (If not institution, give street and number) Sacred Heart Hospital | | 9b. CITY, TOWN OR LOCATION OF DEATH Cumberland | |
| 9c. COUNTY OF DEATH Allegany | | | | 10a. STATE Maryland | | 10b. COUNTY Baltimore | |
| 10c. CITY, TOWN OR LOCATION Baltimore | | | | 10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | 10e. STREET AND NUMBER 1807 Colmar Road | |
| 10f. ZIP CODE 21207 | | | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | | 11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES W.W.II | | | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (1-4 or 5+) | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Tread Mill Operator | | 16b. KIND OF BUSINESS/INDUSTRY Rubber Company | |
| 17. FATHER'S NAME (First, Middle, Last) Daniel Vincent Nolan | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Mary Bailey | | | |
| 19a. INFORMANT'S NAME (Type/Print) Denise Nolan | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11108 Cash Valley Rd. N.W. LaVale, Md. 21502 | | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Rest Lawn Memorial Park 7/6/95 | | 20c. LOCATION — City or Town, State LaVale, Maryland | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE  | | | | 22. NAME AND ADDRESS OF FACILITY Durst Funeral Home 57 Frost Avenue Frostburg, Md. 21532 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → ACUTE RESPIRATORY FAILURE DUE TO (OR AS A CONSEQUENCE OF): b. ACUTE CEREBRAL VASCULAR ACCIDENT DUE TO (OR AS A CONSEQUENCE OF): c. ARTERIOSCLEROTIC VASCULAR DISEASE DUE TO (OR AS A CONSEQUENCE OF): d. Approximate Interval Between Onset and Death 15 MINUTES 12 Hours Unknown Years | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. SEPTICEMIA, CHRONIC OBSTRUCTIVE LUNG DISEASE Old CEREBRAL INFARCT. | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | | | | |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | | | | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | |
| 27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | |
| 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | 28d. DESCRIBE HOW INJURY OCCURRED | | | |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER  | | | | 29c. LICENSE NUMBER D25638 | | 29d. DATE SIGNED (Month, Day, Year) JULY 4, 1995 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) SATURNINA CHANG M.D. Rt 36 FROSTBURG PLAZA FROSTBURG MARYLAND 21532 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JUL 06 1995 | | | | 32. REGISTRAR SIGNATURE  | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 21860

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) MARY ELIZABETH OWINGS | | | | 2. DATE OF DEATH MONTH JULY DAY 8 , YEAR 1995 | | 3. TIME OF DEATH 1:45 A M | |
| 4. SOCIAL SECURITY NUMBER 213-52-6495 | | 5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 77 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) Nov. 17, 1917 | |
| 9a. FACILITY NAME (If not institution, give street and number) WESTMINSTER NURSING HOME | | | | 9b. CITY, TOWN OR LOCATION OF DEATH WESTMINSTER | | 9c. COUNTY OF DEATH CARROLL | |
| RESIDENCE OF DECEDENT | | | | | | | |
| 10a. STATE MARYLAND | | 10b. COUNTY CARROLL | | 10c. CITY, TOWN OR LOCATION WESTMINSTER | | 10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 10e. STREET AND NUMBER 2417 NICODEMUS RD. | | | | 10f. ZIP CODE 21157 | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: WHITE | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 11 College (13-16 or 17+) | | 15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Housewife | | 16b. KIND OF BUSINESS/INDUSTRY Homemaker | | | |
| 17. FATHER'S NAME (First, Middle, Last) WILLIAM A. RUPPERT | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) MARGARET MILLS | | | |
| 19a. INFORMANT'S NAME (Type/Print) JAMES A. OWINGS | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2417 NICODEMUS RD. WESTMINSTER, MD. 21157 | | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) WESTMINSTER CEMETERY 7/11 | | 20c. LOCATION — City or Town, State Westminster, Md. | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i> | | | | 22. NAME AND ADDRESS OF FACILITY FLETCHER FUNERAL HOME 254 E. MAIN ST. WESTMINSTER, MD. 21157 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. CEREBRAL VASCULAR ACCIDENT DUE TO (OR AS A CONSEQUENCE OF): b. CARDIAC ARRHYTHMIA DUE TO (OR AS A CONSEQUENCE OF): c. ARTERIOSCLEROTIC CARDIOVASCULAR DIS DUE TO (OR AS A CONSEQUENCE OF): d. Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | 28. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i> MD | | | | 29c. LICENSE NUMBER D11496 | | 29d. DATE SIGNED (Month, Day, Year) 7-8-95 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) DANIEL J. WELLIVER MD 912 WASHINGTON RD WESTMINSTER MD 21157 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JUL 10 1995 | | | | 32. REGISTRAR'S SIGNATURE <i>[Signature]</i> | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 21861

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|--|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) EUGENE FRANCIS PETERSON II | | | | 2. DATE OF DEATH MONTH JULY DAY 9 YEAR 1995 | | 3. TIME OF DEATH 5:05 A M | |
| 4. SOCIAL SECURITY NUMBER 213-24-6605 | | 5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 65 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) NOV 10 1929 | |
| 8. BIRTHPLACE (State or Foreign Country) MARYLAND | | | | 9a. FACILITY NAME (If not institution, give street and number) SACRED HEART HOSPITAL | | 9b. CITY, TOWN OR LOCATION OF DEATH CUMBERLAND | |
| 9c. COUNTY OF DEATH ALLEGANY | | | | 10a. STATE MARYLAND | | 10b. COUNTY ALLEGANY | |
| 10c. CITY, TOWN OR LOCATION CUMBERLAND | | | | 10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | 10e. STREET AND NUMBER 710 FREDERICK STREET | |
| 10f. ZIP CODE 21502 | | | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | | 11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE YEAR OR DATES U.S. NAVY | | | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: WHITE | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) U.S. NAVY | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) U.S. NAVY | | 16b. KIND OF BUSINESS/INDUSTRY U.S. NAVY | |
| 17. FATHER'S NAME (First, Middle, Last) EUGENE FRANCIS PETERSON SR. | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) NELLIE V. RYAN | | | |
| 19a. INFORMANT'S NAME (Type/Print) LINDA J. PETERSON | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 710 FREDERICK STREET CUMBERLAND MARYLAND 21502 | | | |
| 20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Cumberland Crematory JULY 12 1995 CUMBERLAND MARYLAND | | 20c. LOCATION — City or Town, State | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Dale L. Merritt</i> | | | | 22. NAME AND ADDRESS OF FACILITY MERRITT-ADAMS FUNERAL HOME 404 DECATUR STREET CUMBERLAND MARYLAND | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. End-stage Metastatic Colon Cancer DUE TO (OR AS A CONSEQUENCE OF): Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | |
| 27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | |
| 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | 28d. DESCRIBE HOW INJURY OCCURED | | | |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i> | | | | 29c. LICENSE NUMBER D22181 | | 29d. DATE SIGNED (Month, Day, Year) JULY 9, 1995 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) WAGONER, GARY, M.D. 925 BISHOP WALSH ROAD CUMBERLAND, MD. 21502 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JUL 10 1995 | | | | 32. REGISTRAR'S SIGNATURE <i>[Signature]</i> | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 21862

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|--|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) JAMES F. PUGH | | | | 2. DATE OF DEATH MONTH JULY DAY 4 , YEAR 1995 | | 3. TIME OF DEATH 13:40P M | |
| 4. SOCIAL SECURITY NUMBER 220-16-6593 | | 5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 84 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) June 28, 1911 | |
| 8. BIRTHPLACE (State or Foreign Country) Maryland | | | | 9a. FACILITY NAME (If not institution, give street and number) Sacred Heart Hospital | | 9b. CITY, TOWN OR LOCATION OF DEATH Cumberland | |
| 9c. COUNTY OF DEATH Allegany | | | | 10a. STATE Maryland | | 10b. COUNTY Allegany | |
| 10c. CITY, TOWN OR LOCATION Frostburg | | | | 10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 10e. STREET AND NUMBER 195 Welsh Hill | |
| 10f. ZIP CODE 21532 | | | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | | 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 10 College (1-4 or 5+) Storekeeper | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Storekeeper | | 16b. KIND OF BUSINESS/INDUSTRY Ballistics Laboratory | |
| 17. FATHER'S NAME (First, Middle, Last) Richard Pugh | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Sarah Freal | | | |
| 19a. INFORMANT'S NAME (Type/Print) Myrtle G. Pugh | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 195 Welsh Hill, Frostburg, Md. 21532 | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) St. Michael Cemetery | | 20c. LOCATION — City or Town, State 7/7 Frostburg, Maryland | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>John P. Han</i> | | | | 22. NAME AND ADDRESS OF FACILITY 57 Frost Ave. Durst Funeral Home, Frostburg, Md. 21532 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → Carcinoma of Stomach w/ obstruction Approximate interval Between Onset and Death 1 mo | | | | | | | |
| Due to (or as a consequence of): Renal Failure 1 week | | | | | | | |
| Due to (or as a consequence of): Pneumonia 1 day | | | | | | | |
| Due to (or as a consequence of): | | | | | | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER <i>Angel H. Roane</i> | | | | 29c. LICENSE NUMBER 013166 | | 29d. DATE SIGNED (Month, Day, Year) JULY 5, 1995 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) ANGEL H. ROANE 48 TARN Terrace Frostburg Md 21532 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JUL 10 1995 | | | | REGISTERAR'S SIGNATURE <i>Richard R. Hall</i> | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. The first part of the report deals with the general situation of the country and the progress of the work during the year. It is divided into two main sections: the first section deals with the general situation of the country and the progress of the work during the year, and the second section deals with the specific results of the work.


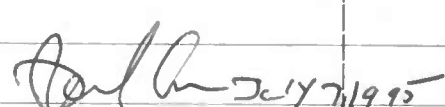
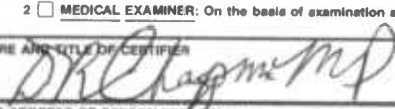

2. The second part of the report deals with the specific results of the work. It is divided into three main sections: the first section deals with the results of the work in the field of agriculture, the second section deals with the results of the work in the field of industry, and the third section deals with the results of the work in the field of commerce.

3. The third part of the report deals with the conclusions and recommendations. It is divided into two main sections: the first section deals with the conclusions and the second section deals with the recommendations.

95 21863

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) Mildred E. Palmer | | | | 2. DATE OF DEATH MONTH DAY YEAR July 2 1995 | | 3. TIME OF DEATH 4:45 a. M | |
| 4. SOCIAL SECURITY NUMBER 218-70-1862 | | 5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 77 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) Aug. 7, 1917 | |
| 9a. FACILITY NAME (If not institution, give street and number) Rt. 3, Box 10A-2 | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Rawlings | | 9c. COUNTY OF DEATH Allegany | |
| 10a. STATE Maryland | | 10b. COUNTY Allegany | | 10c. CITY, TOWN OR LOCATION Rawlings | | 10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| 10e. STREET AND NUMBER Rt. 3, Box 10A-2 | | | | 10f. ZIP CODE 21557 | | 10g. CITIZEN OF WHAT COUNTRY? USA | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (1-4 or 5+) College | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Homemaker | | 16b. KIND OF BUSINESS/INDUSTRY Own Home | | | |
| 17. FATHER'S NAME (First, Middle, Last) Albert Viney, Sr. | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Grace Lynn Willis | | | |
| 19a. INFORMANT'S NAME (Type/Print) Willard W. Palmer | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rt. 3, Box 10A-2 Rawlings, MD 21557 | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Potomac Memorial Gardens 1995 | | 20c. LOCATION — City or Town, State Keyser, WV | | 20d. DATE July 5 | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE  | | | | 22. NAME AND ADDRESS OF FACILITY Rotruck-Smith Funeral Home 85 S. Main Street Keyser, WV 26726 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | | a. Acute Myocardial Infarction DUE TO (OR AS A CONSEQUENCE OF): | | | | Approximate Interval Between Onset and Death 10 minutes | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST | | b. CAD DUE TO (OR AS A CONSEQUENCE OF): | | | | 10 years | |
| | | c. DUE TO (OR AS A CONSEQUENCE OF): | | | | | |
| | | d.  July 7, 1995 | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Long standing diabetes mellitus | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? released 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| | | 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. PLACE OF INJURY — All home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER  | | | | 29c. LICENSE NUMBER WV10799 | | 29d. DATE SIGNED (Month, Day, Year) July 3, 1995 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) David R. Chapman, M.D. P.O. Box "N" Keyser, WV 26726 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JUL 06 1995 | | 32. REGISTRAR'S SIGNATURE  | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 21864

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) Beatrice C. Pinkett | | | | 2. DATE OF DEATH MONTH DAY YEAR June 21 1995 | | 3. TIME OF DEATH M | |
| 4. SOCIAL SECURITY NUMBER 219-36-6612 | | 5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 53 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) April 6, 1942 | |
| 8. BIRTHPLACE (State or Foreign Country) Melilot, Maryland | | | | 9a. FACILITY NAME (If not institution, give street and number) Residence | | 9b. CITY, TOWN OR LOCATION OF DEATH Chestertown | |
| 9c. COUNTY OF DEATH Kent County | | | | 10a. STATE MD | | | |
| 10b. COUNTY Kent | | | | 10c. CITY, TOWN OR LOCATION Chestertown | | | |
| 10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | 10e. STREET AND NUMBER 23672 L Road | | | |
| 10f. ZIP CODE 21620 | | | | 10g. CITIZEN OF WHAT COUNTRY? USA | | | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: Black | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 6th College (1-4 or 5+) | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Housewife | | 16b. KIND OF BUSINESS/INDUSTRY Domestic | |
| 17. FATHER'S NAME (First, Middle, Last) Owen Webb Towson | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Daisey E. Williams | | | |
| 19a. INFORMANT'S NAME (Type/Print) Lawrence B. Pinkett | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 23672 L Road, Chestertown, Maryland 21620 | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Prayer Band Of Faith Cemetery | | 20c. LOCATION — City or Town, State Coleman Maryland | | 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | |
| 22. NAME AND ADDRESS OF FACILITY Bennie Smith Funeral Home, Chestertown MD | | | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. BRUIST CHYLON DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | | | 28e. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | 29b. SIGNATURE AND TITLE OF CERTIFIER | | | |
| 29c. LICENSE NUMBER 17-13824 | | | | 29d. DATE SIGNED (Month, Day, Year) 6-28-95 | | | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JUL 03 '95 | | | | 32. REGISTRAR'S SIGNATURE | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

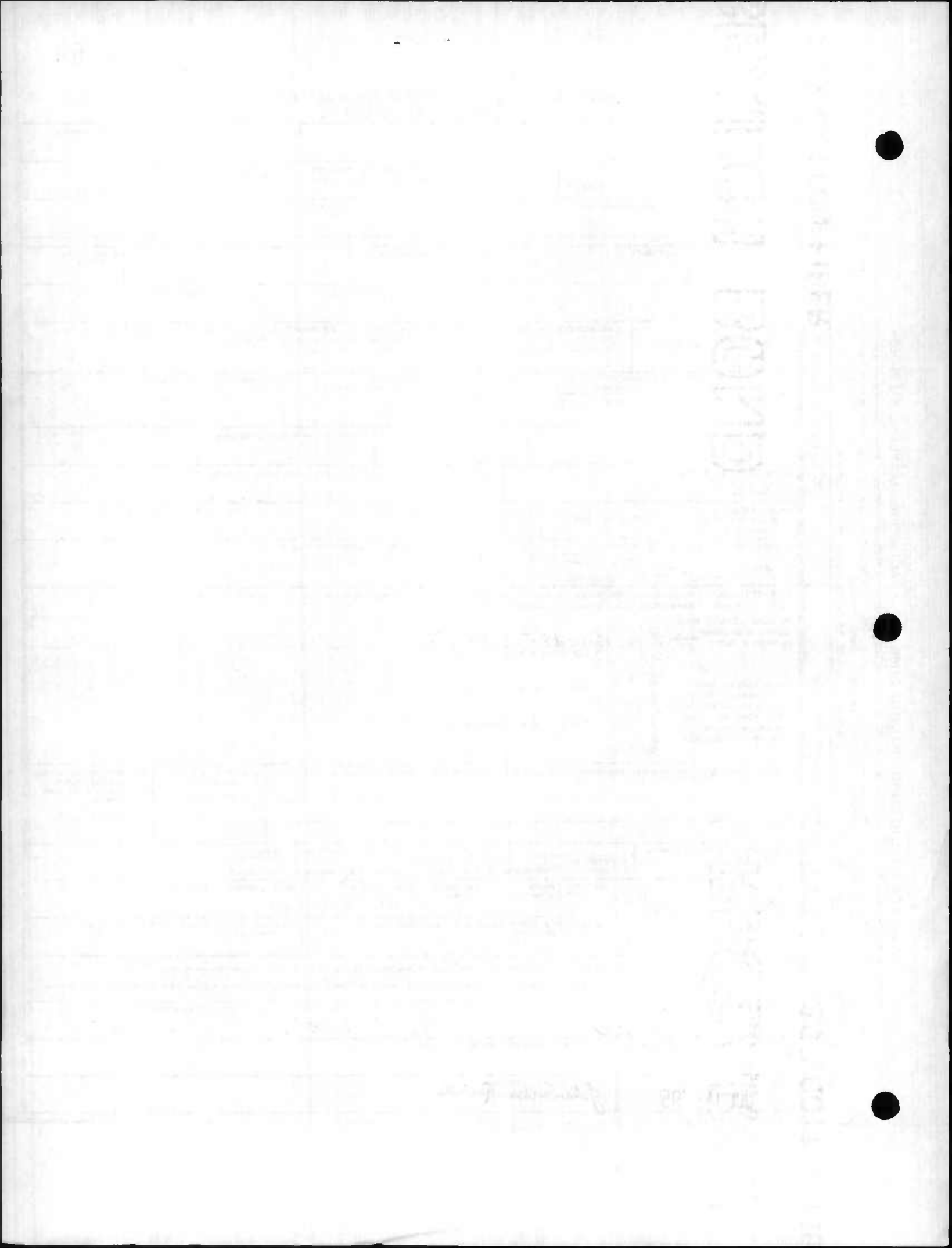
TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 21865

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

| | | | | | | | |
|---|--|---|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) Anne M. Rice | | | | 2. DATE OF DEATH MONTH DAY YEAR July 10 1995 | | 3. TIME OF DEATH 5:00A M | |
| 4. SOCIAL SECURITY NUMBER 216-46-9047 | | 5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 84 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) April 4 1911 | |
| 8. BIRTHPLACE (State or Foreign Country) Washington, D.C. | | | | 9a. FACILITY NAME (If not institution, give street and number) Pleasant Living Convalescent Ctr. | | 9b. CITY, TOWN OR LOCATION OF DEATH Edgewater | |
| 9c. COUNTY OF DEATH Anne Arundel | | | | 10a. STATE MD | | 10b. COUNTY Montgomery | |
| 10c. CITY, TOWN OR LOCATION Silver Spring | | | | 10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 10e. STREET AND NUMBER 3516 Chiswick Court | |
| 10f. ZIP CODE 20906 | | | | 10g. CITIZEN OF WHAT COUNTRY? United States | | 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 2 College (1-4 or 5+) 2 | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Homemaker | | 16b. KIND OF BUSINESS/INDUSTRY Home | |
| 17. FATHER'S NAME (First, Middle, Last) Francis Machen | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Harriet Slemam | | | |
| 19a. INFORMANT'S NAME (Type/Print) Richard A. Rice | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 303 Melvin Avenue Annapolis, Maryland 21401 | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Gate of Heaven Cemetery 7/13/95 | | 20c. LOCATION — City or Town, State Silver Spring, Maryland | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | | | | 22. NAME AND ADDRESS OF FACILITY John M. Taylor Funeral Home 147 Duke of Gloucester St. Annapolis, MD | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. METASTATIC COLON CARCINOMA DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): Approximate Interval Between Onset and Death ≈ 1 yr | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER | | | | 29c. LICENSE NUMBER D 38958 | | 29d. DATE SIGNED (Month, Day, Year) July 10 1995 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Daljeet Sidhu, M.D. 1413 Annapolis Road Suite 106 Odenton, MD 21113(410-674-3222) | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JUL 10 1995 | | | | 32. REGISTRAR'S SIGNATURE | | | |

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 21866

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|--|--|--|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) TOSHICO RICE | | | | 2. DATE OF DEATH MONTH JUL DAY 9 YEAR 1995 | | 3. TIME OF DEATH 2:58 P | |
| 4. SOCIAL SECURITY NUMBER 142-36-1559 | | 5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F | 6. AGE (In yrs. last birthday) 63 YRS. | IF UNDER 1 YEAR MONTHS 0 DAYS 0 | IF UNDER 24 HRS. HOURS 0 MIN. 0 | 7. DATE OF BIRTH (Month, Day, Year) Jan 1, 1932 | |
| 9a. FACILITY NAME (If not institution, give street and number) NATIONAL NAVAL MEDICAL CENTER | | | | 9b. CITY, TOWN OR LOCATION OF DEATH BETHESDA | | 9c. COUNTY OF DEATH MONTGOMERY | |
| 10a. STATE Maryland | | | | 10b. COUNTY Prince George's | | 10c. CITY, TOWN OR LOCATION District Heights | |
| 10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | 10e. STREET AND NUMBER 1964 Rochelle Ave # 923 | | | |
| 10f. ZIP CODE 20747 | | | | 10g. CITIZEN OF WHAT COUNTRY? United States | | | |
| 11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: Oriental | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12th College (1-4 or 5+) Housewife | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Housewife | | 16b. KIND OF BUSINESS/INDUSTRY Own Home | | | |
| 17. FATHER'S NAME (First, Middle, Last) Tomohei Watanabe | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Taki Yamada | | | |
| 19a. INFORMANT'S NAME (Type/Print) Joseph Rice | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1964 Rochelle Ave #923 Dist. Hgts, MD 20747 | | | |
| 20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Lee Crematory July 11, 1995 | | 20c. LOCATION — City or Town, State Clinton, Md | | 21. SIGNATURE OF FUNERAL SERVICE LICENSEE St. F. Smith | |
| 22. NAME AND ADDRESS OF FACILITY Lee Funeral Home, Inc 6633 Old Alexandria Ferry Rd Clinton | | | | 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → INTRACEREBRAL HEMORRHAGE a. DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | 29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER John F. Hawley | | | | 29c. LICENSE NUMBER 212960118 | | 29d. DATE SIGNED (Month, Day, Year) 7/10/95 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) JOHN F. HAWLEY, LT. MC. USNR BETHESDA MD 20889-5600 | | | | 31. DATE FILED (Month, Day, Year) JUL 11 1995 | | | |
| 32. REGISTRAR'S SIGNATURE John Hawley | | | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 21867

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) Robert L. Rush | | | | 2. DATE OF DEATH MONTH JULY DAY 6 YEAR 1995 | | 3. TIME OF DEATH 11:32 AM | |
| 4. SOCIAL SECURITY NUMBER 217-28-0475 | | 5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 60 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) OCT. 10, 1934 | |
| 9a. FACILITY NAME (If not institution, give street and number) UNIVERSITY HOSPITAL | | | | 9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE | | 9c. COUNTY OF DEATH BALTIMORE | |
| 10a. STATE MARYLAND | | | | 10b. COUNTY GARRETT | | 10c. CITY, TOWN OR LOCATION FROSTBURG | |
| 10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | 10e. STREET AND NUMBER 20720 NATIONAL PIKE | | 10f. ZIP CODE 21532 | |
| 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | | | | 11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | |
| 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | | | 14. RACE — American Indian, Black, White, etc. Specify: WHITE | | 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 10 College (1-4 or 5+) OWNERS OPERATOR | |
| 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) OWNERS OPERATOR | | | | 16b. KIND OF BUSINESS/INDUSTRY SALVAGE YARD | | | |
| 17. FATHER'S NAME (First, Middle, Last) RANDOLPH RUSH | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) MADEL MCKENZIE | | | |
| 19a. INFORMANT'S NAME (Type/Print) EVELYN RUSH | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20720 NATIONAL PIKE, FROSTBURG, MD. 21532 | | | |
| 20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) SMITHSBURG CREMATORY 7/7 | | | |
| 20c. LOCATION — City or Town, State SMITHSBURG, MD. | | | | 21. SIGNATURE OF FUNERAL SERVICE LICENSEE John P. Horn | | | |
| 22. NAME AND ADDRESS OF FACILITY 57 FROST AVE. 21532 DURST FUNERAL HOME, FROSTBURG, MD. | | | | 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. Sepsis DUE TO (OR AS A CONSEQUENCE OF): b. multiple trauma sustained during motor vehicle accident DUE TO (OR AS A CONSEQUENCE OF): c. Ethanol intoxication DUE TO (OR AS A CONSEQUENCE OF): d. Approximate interval between Onset and Death 90 hours 5 Days D.C. APPROVED | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Alcoholism | | | | 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | |
| 27. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide | | | | 28a. DATE OF INJURY (Month, Day, Year) JULY 1 1995 | | | |
| 28b. TIME OF INJURY M | | | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | |
| 28d. DESCRIBE HOW INJURY OCCURRED Single vehicle accident | | | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) ROUTE 40 NEAR FROSTBURG | | | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) GARRETT COUNTY, MD. | | | | 29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER Frank J. Collins MD | | | | 29c. LICENSE NUMBER D46081 | | | |
| 29d. DATE SIGNED (Month, Day, Year) July 6, 1995 | | | | 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) University of Maryland Shock Trauma Center | | | |
| 31. DATE FILED (Month, Day, Year) JUL 10 1995 | | | | 32. REGISTRAR'S SIGNATURE Theresa R. Riddell | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.




TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 21868

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) MARY W. Riffle | | | | 2. DATE OF DEATH MONTH July DAY 4 YEAR 1995 | | 3. TIME OF DEATH 0945 M | |
| 4. SOCIAL SECURITY NUMBER 236-14-0451 | | 5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 76 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) July 31 1918 | |
| 9a. FACILITY NAME (If not institution, give street and number) PENINSULA REGIONAL MEDICAL CENTER | | | | 9b. CITY, TOWN OR LOCATION OF DEATH SALISBURY | | 9c. COUNTY OF DEATH WICOMICO | |
| 10a. STATE WV | | | | 10b. COUNTY Mineral | | 10c. CITY, TOWN OR LOCATION Burlington | |
| 10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | 10e. STREET AND NUMBER Rt 1 Box 63 | | | |
| 10f. ZIP CODE 26710 | | | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | | | |
| 11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 11 College (1-4 or 5+) | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Practical Nurse | | 16b. KIND OF BUSINESS/INDUSTRY Hospital | | | |
| 17. FATHER'S NAME (First, Middle, Last) Reuben Heitt Corbin | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Marida Catherine Cosner | | | |
| 19a. INFORMANT'S NAME (Type/Print) Rex. A. Riffle | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) P.O. Box 124 Burlington, WV 26710 | | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Forest Glen Cemetery July 7, 1995 | | 20c. LOCATION — City or Town, State Green Spring, WV | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE  | | | | 22. NAME AND ADDRESS OF FACILITY Rotruck-Smith Funeral Home 85 South Main Street Keyser, WV 26726 | | | |
| 23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. HEART FAILURE DUE TO (OR AS A CONSEQUENCE OF): b. MITRAL VALVE STENOSIS DUE TO (OR AS A CONSEQUENCE OF): c. RHEUMATIC HEART DISEASE DUE TO (OR AS A CONSEQUENCE OF): d. Approximate Interval Between Onset and Death 2 WKS 33 YRS. 35 YRS. | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. PNEUMONIA | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | | | 28e. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER  | | | | 29c. LICENSE NUMBER D20912 | | 29d. DATE SIGNED (Month, Day, Year) 7-4-95 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) DENNIS CHODNICKI, MD 2000 + LOCUST ST. SALISBURY, MD 21801 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JUL 06 1995 | | 32. REGISTRAR'S SIGNATURE  | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

JUL 06 1995

JUL 06 1995

95 21869

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) Nancy Katherine Rodgers | | | | 2. DATE OF DEATH MONTH DAY YEAR June 27, 1995 | | 3. TIME OF DEATH 1545 M | |
| 4. SOCIAL SECURITY NUMBER 219-44-1695 | | 5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 54 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) July 30, 1940 | |
| 8. BIRTHPLACE (State or Foreign Country) Maryland | | | | 9a. FACILITY NAME (If not Institution, give street and number) Kent & Queen Anne's Co. Hospital Inc | | 9b. CITY, TOWN OR LOCATION OF DEATH Chestertown | |
| 9c. COUNTY OF DEATH Kent | | | | 10a. STATE Maryland | | 10b. COUNTY Queen Annes | |
| 10c. CITY, TOWN OR LOCATION Crumpton | | | | 10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 10e. STREET AND NUMBER Andrews Drive - Lot 13, Box 52 | |
| 10f. ZIP CODE 21628 | | | | 10g. CITIZEN OF WHAT COUNTRY? United States | | 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced | |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (9-12) 11 College (1-4 or 5+) 11 | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Homemaker | | 16b. KIND OF BUSINESS/INDUSTRY Domestic / Own Home | |
| 17. FATHER'S NAME (First, Middle, Last) Clifton Ross | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Helen Blevins | | | |
| 19a. INFORMANT'S NAME (Type/Print) Mrs. Helen B. Ross | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) Andrews Drive - Lot 13, Box 52, Crumpton, Maryland 21628 | | | |
| 20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Capitol Crematory - June 30, 1995 | | 20c. LOCATION — City or Town, State Dover, Delaware | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE William L. King Jr. | | | | 22. NAME AND ADDRESS OF FACILITY Fellows - Wells Funeral Home 413 West High Street - Chestertown, Maryland 21620 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. pneumonia DUE TO (OR AS A CONSEQUENCE OF): Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. b. lung transplant | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28d. DESCRIBE HOW INJURY OCCURRED | | | | | |
| 28e. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER m. [Signature] | | | | 29c. LICENSE NUMBER 033514 | | 29d. DATE SIGNED (Month, Day, Year) 6-28-95 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JUL 03 '95 | | | | 32. REGISTRAR'S SIGNATURE John Davidson-Randall | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 21870

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|--|--|---|--------------------------------|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) PEARL E. SPRUILL | | | | 2. DATE OF DEATH MONTH 07 DAY 03 YEAR 95 | | 3. TIME OF DEATH 1800 M | |
| 4. SOCIAL SECURITY NUMBER 214-30-9081 | | 5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F | 6. AGE (In yrs. last birthday) 60 YRS. | IF UNDER 1 YEAR MONTHS DAYS | IF UNDER 24 HRS. HOURS MIN. | 7. DATE OF BIRTH (Month, Day, Year) DEC. 6 1934 | |
| 9a. FACILITY NAME (If not Institution, give street and number) ANNE ARUNDEL MEDICAL CENTER | | | | 9b. CITY, TOWN OR LOCATION OF DEATH ANNAPOLIS | | 9c. COUNTY OF DEATH ANNE ARUNDEL | |
| RESIDENCE OF DECEDENT | | | | | | | |
| 10a. STATE MARYLAND | | 10b. COUNTY ANNE ARUNDEL | | 10c. CITY, TOWN OR LOCATION ANNAPOLIS | | 10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | |
| 10e. STREET AND NUMBER 2 WOMACK DRIVE | | | | 10f. ZIP CODE 21401 | | 10g. CITIZEN OF WHAT COUNTRY? USA | |
| 11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: BLACK | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12th College (1-4 or 5+) 4+ | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) GUIDANCE COUNSELOR | | 16b. KIND OF BUSINESS/INDUSTRY A.A. CO. BOARD OF EDUCATION | | | |
| 17. FATHER'S NAME (First, Middle, Last) BENJAMIN DOUGLAS | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) MILDRED DEMBY | | | |
| 19a. INFORMANT'S NAME (Type/Print) HARRIELL SPRUILL | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 WOMACK DRIVE ANNAPOLIS, MD. 21401 | | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) HILL CREST CEMETERY | | DATE 7/10/95 | | 20c. LOCATION — City or Town, State ANNAPOLIS, MD. | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Harry S. Reese | | | | 22. NAME AND ADDRESS OF FACILITY REESE & SONS MORTUARY, P.A. 821 WEST ST. ANNAPOLIS, MD. 21401 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Upper GI Hemorrhage DUE TO (OR AS A CONSEQUENCE OF): b. Portal hypertension DUE TO (OR AS A CONSEQUENCE OF): c. Hepatic cirrhosis DUE TO (OR AS A CONSEQUENCE OF): d. Ethanol abuse Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | | Approximate Interval Between Onset and Death 48 hrs. |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| | | 28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28e. DESCRIBE HOW INJURY OCCURRED | | | |
| 29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. SIGNATURE AND TITLE OF CERTIFIER Michael N. Keen | | 29c. LICENSE NUMBER D27809 | | 29d. DATE SIGNED (Month, Day, Year) 7/3/95 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Franklin / Cathedral Streets (AAUC) Annapolis MD. | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JUL 10 1995 | | | | 32. REGISTRAR'S SIGNATURE Gabin Arundel-Randall | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

ITEMS: 23 PART I, 27, PER MEO FILM G-725 7/31/95 t.t

1 - FOR
STATE
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

| | | | | | | | | | |
|--|--|--|--|---|--|--|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) MARIE | | | | 2. DATE OF DEATH MONTH JULY DAY 03 YEAR 95 | | | | 3. TIME OF DEATH 1:05 P.M. | |
| 4. SOCIAL SECURITY NUMBER 214-56-1121 | | 5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 46 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) FEB. 2 1949 | | 8. BIRTHPLACE (State or Foreign Country) MARYLAND | |
| 9a. FACILITY NAME (If not institution, give street and number) 1447 TYLER AVE | | | | 9b. CITY, TOWN OR LOCATION OF DEATH ANNAPOLIS | | | | 9c. COUNTY OF DEATH ANNE ARUNDEL | |
| 10a. STATE MARYLAND | | 10b. COUNTY ANNE ARUNDEL | | 10c. CITY, TOWN OR LOCATION ANNAPOLIS | | | | 10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | |
| 10e. STREET AND NUMBER 1447 TYLER AAVENUE | | | | 10f. ZIP CODE 21403 | | 10g. CITIZEN OF WHAT COUNTRY? USA | | | |
| 11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | | | 14. RACE — American Indian, Black, White, etc. Specify: BLACK | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12th College (1-4 or 5+) 0 | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) MAINTANCE | | 16b. KIND OF BUSINESS/INDUSTRY NO SLOT COMPANY | | | |
| 17. FATHER'S NAME (First, Middle, Last) WILTON SIMMS | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) MARIE LEE | | | | | |
| 19a. INFORMANT'S NAME (Type/Print) VIOLA SIMMS | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5 LEE STREET ANNAPOLIS, MD. 21401 | | | | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) ANNAPOLIS MEM. GARDENS 7/8/95 | | | | 20c. LOCATION — City or Town, State ANNAPOLIS, MD. | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Larry H. Reese</i> | | | | 22. NAME AND ADDRESS OF FACILITY REESE & SONS MORTUARY, P.A. 821 WEST ST. ANNAPOLIS, MD. 21401 | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → ATHEROSCLEROTIC CARDIOVASCULAR DISEASE DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST a. DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. | | | | | | | | Approximate interval Between Onset and Death | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | |
| 27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED | |
| 28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28e. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | |
| 29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER <i>Marjorie P. Korell</i> | | | | 29c. LICENSE NUMBER O.C.M.E. | | 29d. DATE SIGNED (Month, Day, Year) JULY 4, 1995 | | | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) MARJORIE P. KORELL 111 Penn Street, Baltimore, Maryland 21201 | | | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JUL 10 1995 | | | | 32. REGISTRAR'S SIGNATURE <i>Julia Anderson Randall</i> | | | | | |

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 5 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 21872

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) John A. Stewart | | | | 2. DATE OF DEATH MONTH DAY YEAR July 6, 1995 | | 3. TIME OF DEATH 12:46 AM | |
| 4. SOCIAL SECURITY NUMBER 229-34-3582 | | 5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 62 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) Aug 3, 1932 | |
| 8. FACILITY NAME (If not institution, give street and number) Southern Maryland Hospital | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Clinton | | 9c. COUNTY OF DEATH Prince Georges | |
| 10a. STATE Maryland | | | | 10b. COUNTY Prince George's | | 10c. CITY, TOWN OR LOCATION Forestville | |
| 10d. INSIDE CITY LIMITS <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | 10e. STREET AND NUMBER 2715 Lorrying Drive | | | |
| 10f. ZIP CODE 20974 | | | | 10g. CITIZEN OF WHAT COUNTRY? United States | | | |
| 11. MARITAL STATUS 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES 1968-1992 | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) College | | 15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Retired Airforce | | 15b. KIND OF BUSINESS/INDUSTRY Korea | | | |
| 17. FATHER'S NAME (First, Middle, Last) Willard Carl Stewart | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Grace Ray Patterson | | | |
| 19a. INFORMANT'S NAME (Type/Print) Wanda Lewis | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2715 Larring Drive, Forestville, Md 20974 | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Maryland Veterans Cem July 10, 1995 | | 20c. LOCATION — City or Town, State Cheltenham, Maryland | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | | | | 22. NAME AND ADDRESS OF FACILITY Lee Funeral Home, Inc 6633 Old Alexandria Ferry Rd, Clinton, MD | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | | a. Seizures DUE TO (OR AS A CONSEQUENCE OF): | | | | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | b. Aspiration Pneumonia DUE TO (OR AS A CONSEQUENCE OF): | | | | | |
| | | c. DUE TO (OR AS A CONSEQUENCE OF): | | | | | |
| | | d. DUE TO (OR AS A CONSEQUENCE OF): | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. chronic pancreatitis, Cirrhosis | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/> | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER | | | | 29c. LICENSE NUMBER D26350 | | 29d. DATE SIGNED (Month, Day, Year) July 11, 1995 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Oswald L. Haye, M.D. 9131 Piscataway Rd. #540 Clinton, Md. 20735 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JUL 11 1995 | | | | 32. REGISTRAR'S SIGNATURE | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 21873

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|---|--|--|--|--|---|
| 1. DECEDENT'S NAME (First, Middle, Last) Edward Lee Staley | | | | 2. DATE OF DEATH MONTH DAY YEAR July 7 1995 | | 3. TIME OF DEATH 10:50P M | |
| 4. SOCIAL SECURITY NUMBER 220-30-7545 | | 5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 59 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) May 16, 1936 | |
| 8. BIRTHPLACE (State or Foreign Country) Maryland | | | | 9a. FACILITY NAME (If not institution, give street and number) 1151 Otterdale Mill Rd. | | 9b. CITY, TOWN OR LOCATION OF DEATH Taneytown | |
| 9c. COUNTY OF DEATH Carroll | | | | 10a. STATE Maryland | | 10b. COUNTY Carroll | |
| 10c. CITY, TOWN OR LOCATION Taneytown | | | | 10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 10e. STREET AND NUMBER 1151 Otterdale Mill Rd. | |
| 10f. ZIP CODE 21787 | | | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | | 11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 12 | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Farmer | | 16b. KIND OF BUSINESS/INDUSTRY Dairy | |
| 17. FATHER'S NAME (First, Middle, Last) Hiram Joshua Staley | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Dorothy Hamilton | | | |
| 19a. INFORMANT'S NAME (Type/Print) Rosemarie Staley | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1151 Otterdale Mill Rd. Taneytown, Md. 21787 | | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Trinity Lutheran Cem. 7/11 | | 20c. LOCATION — City or Town, State Taneytown, Md. | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | | | | 22. NAME AND ADDRESS OF FACILITY D.D. Hartzler Union Bridge, Md. 21791 | | | |
| 23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <u>Acute coronary artery disease</u> DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST | | | | | | | Approximate Interval Between Onset and Death 6 mo |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>mult pulmonary emboli</u> | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | | | | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA <input checked="" type="checkbox"/> OTHER: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER | | | | 29c. LICENSE NUMBER D14626 | | 29d. DATE SIGNED (Month, Day, Year) July 10, 1995 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) J G Dca usc 6 md 501 W 7th St - Frederick MD 21701 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JUL 11 1995 | | | | 32. REGISTRAR'S SIGNATURE | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.


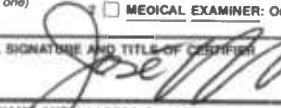
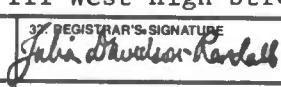
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 21874

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|---|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) Howard John Slagle | | | | 2. DATE OF DEATH MONTH DAY YEAR July 8, 1995 | | 3. TIME OF DEATH 0530 M | |
| 4. SOCIAL SECURITY NUMBER 241-26-7613 | | 5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 74 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) May 10, 1921 | |
| 9a. FACILITY NAME (If not institution, give street and number) 89 Carriage Lane | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Elkton | | 9c. COUNTY OF DEATH Cecil | |
| RESIDENCE OF DECEDENT | | | | | | | |
| 10a. STATE Maryland | | 10b. COUNTY Cecil | | 10c. CITY, TOWN OR LOCATION Elkton | | 10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| 10e. STREET AND NUMBER 89 Carriage Lane | | | | 10f. ZIP CODE 21921 | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES World War II | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (1-4 or 5+) _____ | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired) Owner/Operator General Contractors | | 16b. KIND OF BUSINESS/INDUSTRY Building Construction | | | |
| 17. FATHER'S NAME (First, Middle, Last) Robert Handy Slagle | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Nora CAnipe | | | |
| 19a. INFORMANT'S NAME (Type/Print) Juanita B. Slagle | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 89 Carriage Lane - Elkton, MD 21921 | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Gilpin Manor Memorial Park 7/8/95 | | 20c. LOCATION — City or Town, State Elkton, Maryland | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE  | | | | 22. NAME AND ADDRESS OF FACILITY Hicks Home for Funerals, P.A. 103 West Stockton Street Elkton, MD 21921-5521 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Lung CA (unconfirmed) b. Dehydration / Malnutrition c. _____ d. _____ Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST | | | | | | | Approximate Interval Between Onset and Death |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | | | | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER  | | | | 29c. LICENSE NUMBER D44716 | | 29d. DATE SIGNED (Month, Day, Year) 7/8/95 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Jose Ma, M.D. - 111 West High Street - Elkton, MD 21921 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JUL 10 1995 | | | | 32. REGISTRAR'S SIGNATURE  | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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+10A

95 21875

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | |
|---|--|---|--|---|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) Mary Jane Siti | | | | 2. DATE OF DEATH MONTH DAY YEAR July 6, 1995 | | | | 3. TIME OF DEATH 6:00 P M | |
| 4. SOCIAL SECURITY NUMBER 220-20-6373 | | 5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 68 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) Jan. 30, 1927 | | 8. BIRTHPLACE (State or Foreign Country) Maryland | |
| 9a. FACILITY NAME (If not institution, give street and number) Union Hospital | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Elkton | | | | 9c. COUNTY OF DEATH Cecil County | |
| RESIDENCE OF DECEDENT | | | | | | | | | |
| 10a. STATE Maryland | | 10b. COUNTY Cecil County | | 10c. CITY, TOWN OR LOCATION Chesapeake City | | | | 10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| 10e. STREET AND NUMBER 2936 Old Telegraph Road | | | | 10f. ZIP CODE 21915 | | 10g. CITIZEN OF WHAT COUNTRY? United States | | | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | | 14. RACE — American Indian, Black, White, etc. Specify: White | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 1 yr. | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Clerk | | | 16b. KIND OF BUSINESS/INDUSTRY Government | | | |
| 17. FATHER'S NAME (First, Middle, Last) Norman T. Spear | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Olive L. Baker | | | | | |
| 19a. INFORMANT'S NAME (Type/Print) Sigmund L. Siti | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2936 Old Telegraph Rd., Chesapeake City, MD 21915 | | | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) St. Rose of Lima Cemetery | | | | 20c. LOCATION — City or Town, State Chesapeake City, MD | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Robert J. Board</i> | | | | 22. NAME AND ADDRESS OF FACILITY R.I. Foard Funeral Home 21915 318 George Street, Chesapeake City, MD | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Sepsis DUE TO (OR AS A CONSEQUENCE OF): Pneumonia with pseudomonas DUE TO (OR AS A CONSEQUENCE OF): COPD CHF. DUE TO (OR AS A CONSEQUENCE OF): ASCVD Hypertension Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | | | Approximate Interval Between Onset and Death | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| | | | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED | |
| | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER <i>Amelia Han MD</i> | | | | | | 29c. LICENSE NUMBER D04823 | | 29d. DATE SIGNED (Month, Day, Year) 7-7-95 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 223 W. Main St Elkton, MD 21921 | | | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JUL-7 1995 | | | | 32. REGISTRAR'S SIGNATURE <i>John A. Buckner-Randall</i> | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

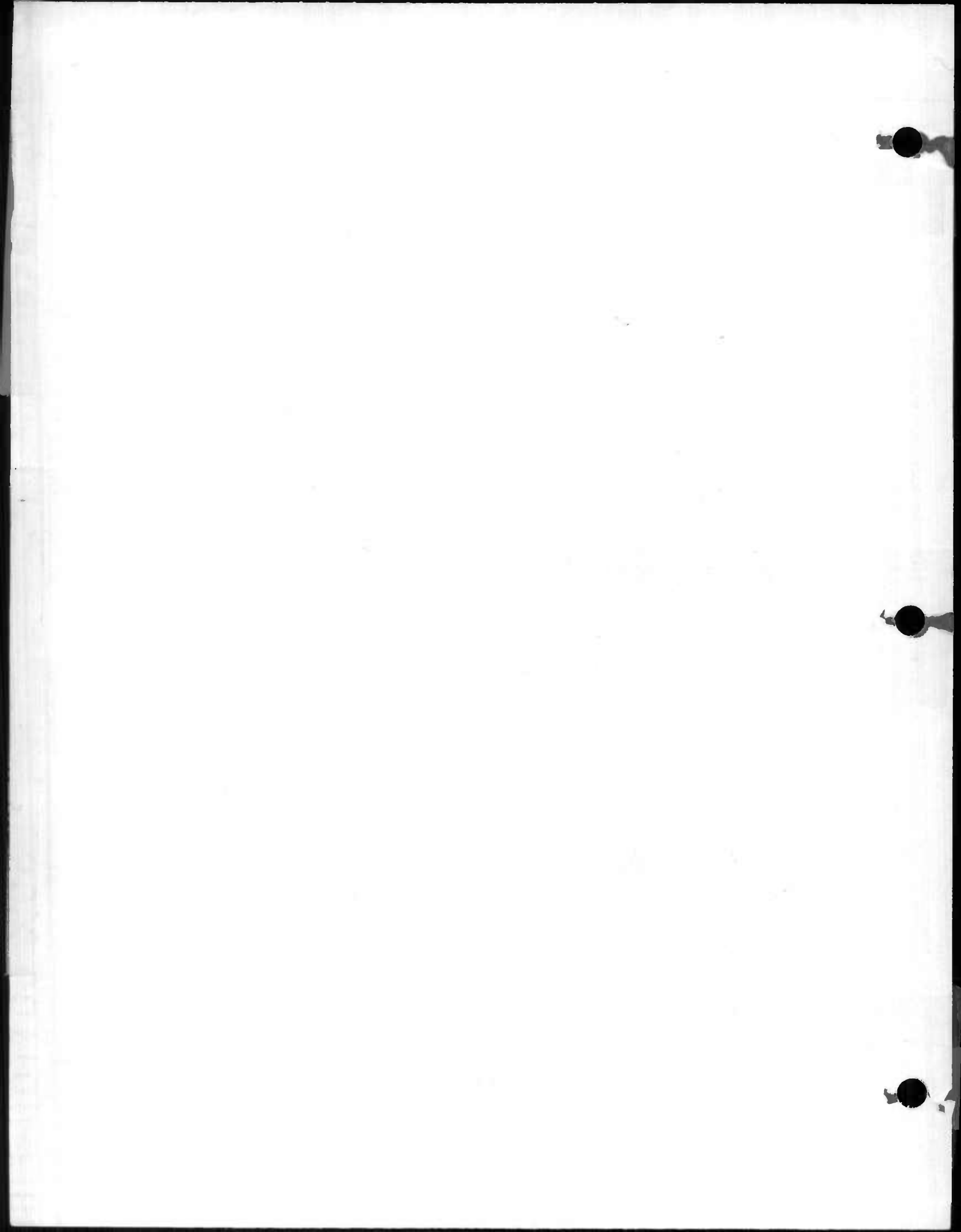
BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 21876

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|--|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) HERBERT GILMORE SHIPPER | | | | 2. DATE OF DEATH MONTH DAY YEAR July 8, 1995 | | 3. TIME OF DEATH 1:15 P M | |
| 4. SOCIAL SECURITY NUMBER 214-07-6194 | | 5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 81 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) MAY 18 1914 | |
| 8. BIRTHPLACE (State or Foreign Country) MARYLAND | | | | 9a. FACILITY NAME (If not institution, give street and number) MEMORIAL HOSPITAL | | 9b. CITY, TOWN OR LOCATION OF DEATH CUMBERLAND | |
| 9c. COUNTY OF DEATH ALLEGANY | | | | 10a. STATE MARYLAND | | 10b. COUNTY ALLEGANY | |
| 10c. CITY, TOWN OR LOCATION CUMBERLAND | | | | 10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 10e. STREET AND NUMBER 810 TROST AVENUE | |
| 10f. ZIP CODE 21502 | | | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | | 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES U.S. ARMY WWII | | | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: WHITE | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) B & O RAILROAD | | | | 16b. KIND OF BUSINESS/INDUSTRY BRAKEMAN/RAILROAD | | | |
| 17. FATHER'S NAME (First, Middle, Last) HARRY GILMORE SHIPPER | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) ADA BLANCHE PARKER | | | |
| 19a. INFORMANT'S NAME (Type/Print) ATTORNEY: MICHAEL STANKAN | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 234 BALTIMORE AVE CUMBERLAND MARYLAND 21502 | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) HILLCREST CEMETERY JULY 12 1995 CUMBERLAND MARYLAND | | 20c. LOCATION — City or Town, State | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Dale L. Merritt</i> | | | | 22. NAME AND ADDRESS OF FACILITY MERRITT-ADAMS FUNERAL HOME 404 DECATUR STREET CUMBERLAND MARYLAND | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Coronary artery disease</i> DUE TO (OR AS A CONSEQUENCE OF): Sequently ill conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, term, street, factory, office building, etc. (Specify) | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER <i>Dr. W. Fiscus</i> | | | | 29c. LICENSE NUMBER D12779 | | 29d. DATE SIGNED (Month, Day, Year) July 10, 1995 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Dr. W. Fiscus Memorial Hospital Medical Building Cumberland, Md. 21502 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JUL 10 1995 | | | | 32. REGISTRAR'S SIGNATURE <i>David R. Hestell</i> | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 21877

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|--|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) Vernon DeSales Snyder | | | | 2. DATE OF DEATH MONTH DAY YEAR July, 2, 1995 | | 3. TIME OF DEATH 10-48 A. M | |
| 4. SOCIAL SECURITY NUMBER 216-22-6939 | | 5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 67 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) Aug. 6, 1927 | |
| 8. BIRTHPLACE (State or Foreign Country) Maryland | | | | 9a. FACILITY NAME (If not institution, give street and number) Memorial Hospital | | 9b. CITY, TOWN OR LOCATION OF DEATH Cumberland | |
| 9c. COUNTY OF DEATH Allegany | | | | 10a. STATE Maryland | | 10b. COUNTY Allegany | |
| 10c. CITY, TOWN OR LOCATION Cumberland | | | | 10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | 10e. STREET AND NUMBER 537 North Mechanic Street | |
| 10f. ZIP CODE 21502 | | | | 10g. CITIZEN OF WHAT COUNTRY? USA | | 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES WW II | | | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | | |
| 14. RACE — American Indian, Black, White, etc. Specify: White | | | | 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) Tire Builder | | | |
| 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Tire Builder | | | | 16b. KIND OF BUSINESS/INDUSTRY Tire & Rubber | | | |
| 17. FATHER'S NAME (First, Middle, Last) Frank Snyder | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Margaret Baker | | | |
| 19a. INFORMANT'S NAME (Type/Print) Paulette Miller | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11031 Highland Dr. Estates N.E. Cumberland, Md. 21502 | | | |
| 20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Resthaven Crematory 7/3/95 | | | |
| 20c. LOCATION — City or Town, State Frederick, Maryland | | | | 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Ernest A. R. [Signature] | | | |
| 22. NAME AND ADDRESS OF FACILITY Leasure-Stein, Inc. 230 Baltimore Avenue Cumberland, Md. 21502 | | | | 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST a. Colon Cancer DUE TO (OR AS A CONSEQUENCE OF): b. Liver Metastasis DUE TO (OR AS A CONSEQUENCE OF): c. Hepatic Encephalopathy DUE TO (OR AS A CONSEQUENCE OF): d. Approximate Interval Between Onset and Death 8 Months 4 Months 3 Days | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide | | | | 28a. DATE OF INJURY (Month, Day, Year) July 2, 1995 | | | |
| 28b. TIME OF INJURY M | | | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER [Signature] | | | | 29c. LICENSE NUMBER D 36766 | | | |
| 29d. DATE SIGNED (Month, Day, Year) July 3, 1995 | | | | 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Dr. V. Poonai 955 Frederick Street Cumberland, Md. 21502 | | | |
| 31. DATE FILED (Month, Day, Year) JUL 08 1995 | | | | 32. REGISTRAR'S SIGNATURE [Signature] | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 21878

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) HARRY VERNON SMITH | | | | 2. DATE OF DEATH MONTH DAY YEAR JULY 5 1995 | | 3. TIME OF DEATH 10:30 P M | |
| 4. SOCIAL SECURITY NUMBER 705-10-7965 | | 5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 88 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) MARCH 4 1907 | |
| 9a. FACILITY NAME (If not institution, give street and number) 12723 BEDFORD ROAD N.E. | | | | 9b. CITY, TOWN OR LOCATION OF DEATH CUMBERLAND | | 9c. COUNTY OF DEATH ALLEGANY | |
| 10a. STATE MARYLAND | | 10b. COUNTY ALLEGANY | | 10c. CITY, TOWN OR LOCATION CUMBERLAND | | 10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| 10e. STREET AND NUMBER 12723 BEDFORD ROAD N.E. | | | | 10f. ZIP CODE 21502 | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: WHITE | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 6 College (1-4 or 5+) 6 | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) WESTERN MD. RAILROAD | | 16b. KIND OF BUSINESS/INDUSTRY BOILER MAKER | | | |
| 17. FATHER'S NAME (First, Middle, Last) JAMES JACKSON SMITH | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) BERTHA GRACE COMER | | | |
| 19a. INFORMANT'S NAME (Type/Print) MARY L. SMITH | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12723 BEDFORD ROAD N.E. CUMBERLAND MARYLAND 21502 | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) ZION MEMORIAL PARK JULY 8 1995 | | 20c. LOCATION — City or Town, State CUMBERLAND MARYLAND | | 22. NAME AND ADDRESS OF FACILITY MERRITT-ADAMS FUNERAL HOME 404 DECATUR STREET CUMBERLAND MARYLAND | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Mary L. Smith</i> | | | | 22. NAME AND ADDRESS OF FACILITY MERRITT-ADAMS FUNERAL HOME 404 DECATUR STREET CUMBERLAND MARYLAND | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → Stroke | | | | | | | |
| DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| b. Cerebral Atherosclerosis | | | | | | | |
| DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| c. Hypertension | | | | | | | |
| DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| d. | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Hypertension | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER <i>Anthony J. Bollino</i> | | | | 29c. LICENSE NUMBER D 17565 | | 29d. DATE SIGNED (Month, Day, Year) JULY 6 1995 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) DR. ANTHONY J. BOLLINO, JR. 955 FREDERICK STREET CUMBERLAND MARYLAND 21502 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JUL 06 1995 | | 32. REGISTRAR'S SIGNATURE <i>John A. Davidson</i> | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

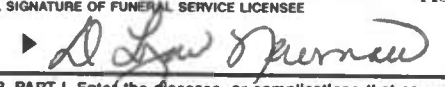
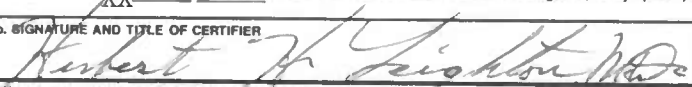
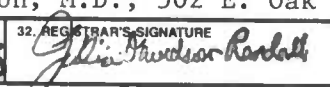
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 21879

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) Bailey Thomas Spiker | | | | 2. DATE OF DEATH MONTH DAY YEAR July 3 1995 | | 3. TIME OF DEATH 10:00 p.m. | |
| 4. SOCIAL SECURITY NUMBER 193-50-8350 | | 5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 60 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) Sept 20, 1934 | |
| 8a. FACILITY NAME (If not institution, give street and number) 605 Meyersdale Road | | | | 8b. CITY, TOWN OR LOCATION OF DEATH Grantsville | | 8c. COUNTY OF DEATH Garrett | |
| 9a. RESIDENCE OF DECEDENT 10a. STATE Maryland 10b. COUNTY Garrett | | | | 10c. CITY, TOWN OR LOCATION Grantsville | | 10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| 10e. STREET AND NUMBER 605 Meyersdale Road | | | | 10f. ZIP CODE 21536 | | 10g. CITIZEN OF WHAT COUNTRY? USA | |
| 11. MARITAL STATUS 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: white | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (9-12) 3 rd College (1-4 or 5+) | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Handicapped | | 16b. KIND OF BUSINESS/INDUSTRY Handicapped | | | |
| 17. FATHER'S NAME (First, Middle, Last) George Henry Spiker | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Annie Christina Merrbach | | | |
| 19a. INFORMANT'S NAME (Type/Print) Minnie A. Teter | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 605 Meyersdale Rd., Grantsville, MD 21536 | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Merrbach Cemetery, July 6, 1995 | | 20c. LOCATION — City or Town, State Grantsville, MD | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE  | | | | 22. NAME AND ADDRESS OF FACILITY Newman Funeral Homes, P.A. 170 Miller St., Grantsville, MD 21536 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Cerebral Vascular Accident DUE TO (OR AS A CONSEQUENCE OF): b. Arteriosclerotic Cardio-Vascular Disease DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Diabetes Mellitus Mental Retardation, congenital DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/> | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| 29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER  | | | | 29c. LICENSE NUMBER D 05658 | | 29d. DATE SIGNED (Month, Day, Year) July 4, 1995 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Herbert H. Leighton, M.D., 502 E. Oak Street, Oakland, MD 21550 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JUL 06 1995 | | | | 32. REGISTRAR'S SIGNATURE  | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 21880

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) TEMPIE SCOTT | | | | 2. DATE OF DEATH MONTH DAY YEAR 6-4-1995 | | 3. TIME OF DEATH 5:00 P.M. | |
| 4. SOCIAL SECURITY NUMBER 214-66-9254 | | 5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 94 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 3-19-1901 | |
| 8. BIRTHPLACE (State or Foreign Country) MD. | | | | 9a. FACILITY NAME (If not institution, give street and number) CHESTER TOWN NURSING HOME | | 9b. CITY, TOWN OR LOCATION OF DEATH CHESTER TOWN | |
| 9c. COUNTY OF DEATH Kent | | | | 10a. STATE MD. | | 10b. COUNTY Kent | |
| 10c. CITY, TOWN OR LOCATION Rock Hall | | | | 10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 10e. STREET AND NUMBER LOVER'S LANE | |
| 10f. ZIP CODE 21661 | | | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | | 11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: BLACK | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 0-8 College (14 or 5+) College | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) HOUSEWIFE | | 16b. KIND OF BUSINESS/INDUSTRY HOME | |
| 17. FATHER'S NAME (First, Middle, Last) SAMUEL MURRAY | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) FLORENCE UNK. | | | |
| 19a. INFORMANT'S NAME (Type/Print) MRS. MAUDE JONES | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) P.O. Box #127 Worton, Md. 21678 | | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematorium or other place) AARON CHASE 6/8/95 | | 20c. LOCATION — City or Town, State Rock Hall, Md. | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Denneth Wall | | | | 22. NAME AND ADDRESS OF FACILITY WALLET FUNERAL HOME CHESTER TOWN, MD. | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Cerebrovascular Disease Approximate Interval Between Onset and Death several years Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | | | 28e. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER C. Gottfried Baumann | | | | 29c. LICENSE NUMBER D00354 | | 29d. DATE SIGNED (Month, Day, Year) 6/15/95 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) C. GOTT FRIED BAUMANN MED. Bldg. CHESTER TOWN MD | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JUN 23 '95 | | | | 32. REGISTRAR'S SIGNATURE J. Davidson-Randall | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 21881

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | | | | |
|--|--|---|--|--|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) ALGER B. Scott (SCOTT) | | | | 2. DATE OF DEATH MONTH July DAY 7 YEAR 1995 | | 3. TIME OF DEATH 2112 P | |
| 4. SOCIAL SECURITY NUMBER 230-07-3179 | | 5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 85 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) May 1, 1910 | |
| 9a. FACILITY NAME (If not institution, give street and number) PENINSULA REGIONAL MEDICAL CENTER | | | | 9b. CITY, TOWN OR LOCATION OF DEATH SALISBURY | | 9c. COUNTY OF DEATH WICOMICO | |
| 10a. STATE Maryland | | 10b. COUNTY Somerset | | 10c. CITY, TOWN OR LOCATION Princess Anne | | 10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 10e. STREET AND NUMBER 11974 Edgehill Terrace | | | | 10f. ZIP CODE 21853 | | 10g. CITIZEN OF WHAT COUNTRY? USA | |
| 11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES World War II | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) Grade 8 College (1-4 or 5+) — — — | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Employee | | 16b. KIND OF BUSINESS/INDUSTRY Frozen Process Food Mfg. | | | |
| 17. FATHER'S NAME (First, Middle, Last) William Thomas Scott | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Olevia Bradford | | | |
| 19a. INFORMANT'S NAME (Type/Print) (step-son) George W. Diggs, Jr. | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21853 10972 Old Princess Anne Road - Princess Anne, MD | | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Sunnyridge Memorial Park 7/10/95 | | 20c. LOCATION — City or Town, State Crisfield, MD | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Robert H. Bradshaw | | | | 22. NAME AND ADDRESS OF FACILITY Bradshaw & Sons Funeral Home 306 W. Main St. - Crisfield, MD 21817 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | | a. Arteriosclerotic Heart Disease | | | | | Approximate Interval Between Onset and Death 3 YRS |
| | | b. Generalized Atherosclerosis | | | | | 3 YRS |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | c. _____ | | | | | |
| | | d. _____ | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Hypertension. Parkinson's Disease Organic Brain Syndrome | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input checked="" type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Nomicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO | |
| 28d. DESCRIBE NOW INJURY OCCURRED | | | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER Gregorio M. Belloso, M.D. | | | | 29c. LICENSE NUMBER D29505 | | 29d. DATE SIGNED (Month, Day, Year) 7/9/95 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Gregorio Belloso, MD - 201 Hall Highway - Crisfield, MD 21817 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JUL 11 1995 | | | | | | | |

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

$$H_2 = 2 - \varepsilon$$

— *Journal of the American Medical Association*

Figure 1. The effect of the concentration of the *Agrobacterium* suspension on the transformation efficiency of *Agrobacterium* strains. The concentration of the *Agrobacterium* suspension was 10⁶ cells/ml (A), 10⁷ cells/ml (B), 10⁸ cells/ml (C), and 10⁹ cells/ml (D). The concentration of the *Agrobacterium* suspension was 10⁶ cells/ml (A), 10⁷ cells/ml (B), 10⁸ cells/ml (C), and 10⁹ cells/ml (D). The concentration of the *Agrobacterium* suspension was 10⁶ cells/ml (A), 10⁷ cells/ml (B), 10⁸ cells/ml (C), and 10⁹ cells/ml (D).

95 21882

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|--------------------|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) James Paul Thomas, Jr. | | | | 2. DATE OF DEATH MONTH DAY YEAR June 25 1995 | | 3. TIME OF DEATH 12:20P M | |
| 4. SOCIAL SECURITY NUMBER 151-22-9617 | | 5. SEX XX M 2 F | | 6. AGE (In yrs. last birthday) 66 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) March 23 1929 | |
| 8. BIRTHPLACE (State or Foreign Country) New Jersey | | | | 9a. FACILITY NAME (If not institution, give street and number) 53 East Lake Drive | | 9b. CITY, TOWN OR LOCATION OF DEATH Annapolis | |
| 9c. COUNTY OF DEATH Anne Arundel | | | | 10a. STATE MD | | 10b. COUNTY Anne Arundel | |
| 10c. CITY, TOWN OR LOCATION Annapolis | | | | 10d. INSIDE CITY LIMITS 1 YES 2 NO | | 10e. STREET AND NUMBER 53 East Lake Drive | |
| 10f. ZIP CODE 21403 | | | | 10g. CITIZEN OF WHAT COUNTRY? United States | | 11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced | |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES | | | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 YES 2 NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 4 plus | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Instructor | | 16b. KIND OF BUSINESS/INDUSTRY Education | |
| 17. FATHER'S NAME (First, Middle, Last) James Paul Thomas, Sr. | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Marie MacNeil | | | |
| 19a. INFORMANT'S NAME (Type/Print) Major General John W. Huston | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 115 East Lake Dr. Annapolis, MD 21403 | | | |
| 20a. METHOD OF DISPOSITION 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) | | | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Ft. Lincoln Crematory 6/28/95 Brentwood, MD | | 20c. LOCATION — City or Town, State | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Walter J. Burdick</i> | | | | 22. NAME AND ADDRESS OF FACILITY John M. Taylor Funeral Home, Inc. 147 Duke of Gloucester St. Annapolis, MD | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. ASCVD | | | | | | | |
| b. DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| c. DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| d. DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO | | | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 Inpatient 2 ER/Outpatient 3 DOA OTHER: 4 Nursing Home 5 Residence 6 Other (Specify) | | | |
| 27. MANNER OF DEATH 1 Natural 2 Accident 3 Suicide 4 Homicide 5 Pending Investigation 6 Could not be determined | | | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M 1 YES 2 NO | |
| 28c. INJURY AT WORK? 1 YES 2 NO | | | | 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. CERTIFIER (Check only one) 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER <i>Kelly Briggs MD</i> | | | | 29c. LICENSE NUMBER D28640 | | 29d. DATE SIGNED (Month, Day, Year) 6/25/95 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 556 Cardinal Drive Pasadena MD 21227 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JUL 10 1995 | | | | 32. REGISTRAR'S SIGNATURE <i>John Andrew Kendall</i> | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 21883

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | | | |
|--|--|---|--|---|--|---|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) BERNARD TAYLOR | | | | 2. DATE OF DEATH MONTH JUNE DAY 24 YEAR 95 | | | | 3. TIME OF DEATH 10:55 A.M. | | | |
| 4. SOCIAL SECURITY NUMBER 217-78-6160 | | 5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 36 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) APRIL 25 1959 | | 8. BIRTHPLACE (State or Foreign Country) MARYLAND | | | |
| 9a. FACILITY NAME (If not institution, give street and number) UNIVERSITY HOSPITAL | | | | 9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE | | | | 9c. COUNTY OF DEATH | | | |
| 10a. STATE MARYLAND | | 10b. COUNTY ANNE ARUNDEL | | 10c. CITY, TOWN OR LOCATION ANNAPOLIS | | | | 10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | | |
| 10e. STREET AND NUMBER 1903 LINCOLN DRIVE | | | | 10f. ZIP CODE 21401 | | 10g. CITIZEN OF WHAT COUNTRY? USA | | | | | |
| 11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: BLACK | | | | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 10th College (1-4 or 5+) 0 | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) LABORER | | 16b. KIND OF BUSINESS/INDUSTRY SELF EMPLOYED | | | | | | | |
| 17. FATHER'S NAME (First, Middle, Last) SMAUEL B. TAYLOR | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) CHARLOTTE RANDALL | | | | | | | |
| 19a. INFORMANT'S NAME (Type/Print) LINDA DIGGS | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 124 MERRYMAN COURT ANNAPOLIS, MD. 21001 | | | | | | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematorium, or other place) ANNAPOLIS MEM. GARDENS 7/3/95 | | 20c. LOCATION — City or Town, State ANNAPOLIS, MD. | | | | | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Larry G. Reese</i> | | | | 22. NAME AND ADDRESS OF FACILITY REESE & SONS MORTUARY, P.A. 821 WEST ST. ANNAPOLIS, MD. 21401 | | | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. PROBABLE ACUTE PULMONARY EMBOLISM DUE TO (OR AS A CONSEQUENCE OF): b. RIGHT PROXIMAL HUMERUS / TIBIAL / FIBULAR FRACTURES DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST d. LEFT FRONTAL PARIENTAL SUBARACHNOID HEMORRHAGE e. RIGHT TEMPOROPARIETAL CEREBRAL CONTUSION DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | | Approximate Interval Between Onset and Death 2 MINUTES 13 DAYS | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. LEFT FRONTAL PARIENTAL SUBARACHNOID HEMORRHAGE RIGHT TEMPOROPARIETAL CEREBRAL CONTUSION DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | | | |
| 27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) JUN 11, 1995 | | 28b. TIME OF INJURY 10:55 A.M. | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED PEDESTRIAN STRUCK BY AUTO | | | |
| 29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i> | | 29c. LICENSE NUMBER D44098 | | 29d. DATE SIGNED (Month, Day, Year) JUN 24, 1995 | | | | | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) HENRY CO, M.D. R. ADAMS COWLEY STROKE TRAUMA CENTER, BALTIMORE, MARYLAND | | | | | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JUL 10 1995 | | | | 32. REGISTRAR'S SIGNATURE <i>[Signature]</i> | | | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 21884

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) <u>James Alfred Thomas</u> | | | | 2. DATE OF DEATH MONTH <u>June</u> DAY <u>19</u> YEAR <u>1995</u> | | 3. TIME OF DEATH <u>0357</u> <u>M</u> | |
| 4. SOCIAL SECURITY NUMBER <u>213-22-5121</u> | | 5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) <u>67</u> YRS. | | 7. DATE OF BIRTH (Month, Day, Year) <u>October 29, 1927</u> | |
| 8. BIRTHPLACE (State or Foreign Country) <u>Maryland</u> | | | | 9. FACILITY NAME (If not institution, give street and number) <u>The Kent and Queen Anne's Hospital</u> | | 10. CITY, TOWN OR LOCATION OF DEATH <u>Chestertown</u> | |
| 11. RESIDENCE OF DECEDENT 10a. STATE <u>Maryland</u> 10b. COUNTY <u>Kent</u> 10c. CITY, TOWN OR LOCATION <u>Millington</u> 10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | 12. STREET AND NUMBER <u>10669 Chesterville Forest Road</u> | | 13. ZIP CODE <u>21651</u> | |
| 14. CITIZEN OF WHAT COUNTRY? <u>United States</u> | | | | 15. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 16. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES <u>World War II</u> | |
| 17. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | | | 18. RACE — American Indian, Black, White, etc. Specify: <u>Black</u> | | 19. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <u>12</u> College (1-4 or 5+) <u></u> | |
| 20. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <u>Laborer</u> | | | | 21. KIND OF BUSINESS/INDUSTRY <u>Horse Farm</u> | | 22. FATHER'S NAME (First, Middle, Last) <u>Wayman Thomas</u> | |
| 23. MOTHER'S NAME (First, Middle, Maiden Surname) <u>Lillie Brown</u> | | | | 24. INFORMANT'S NAME (Type/Print) <u>Josephine Mason</u> | | 25. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>10634 Chesterville Forest Road, Millington, Maryland 21651</u> | |
| 26. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 27. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <u>Chesterville Cemetery - June 24, 1995</u> | | 28. LOCATION — City or Town, State <u>Millington, Maryland</u> | |
| 29. SIGNATURE OF FUNERAL SERVICE LICENSER <u>William L. King Jr.</u> | | | | 30. NAME AND ADDRESS OF FACILITY <u>Fellows Funeral Homes, P.A. Cypress Street, Millington, Maryland</u> | | 31. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <u>acute Esophageal hemorrhage</u> DUE TO (OR AS A CONSEQUENCE OF): <u>Esophageal Varices</u> DUE TO (OR AS A CONSEQUENCE OF): <u>Cirrhosis of the Liver</u> DUE TO (OR AS A CONSEQUENCE OF): <u>ESOPH</u> Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | |
| 32. PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>Renal Failure</u> <u>CNF</u> | | | | 33. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 34. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 35. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | 36. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 37. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | |
| 38. MANNER OF DEATH 1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined | | | | 39. DATE OF INJURY (Month, Day, Year) <u></u> | | 40. TIME OF INJURY <u>M</u> | |
| 41. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | 42. DESCRIBE HOW INJURY OCCURRED <u></u> | | 43. LOCATION (Street and Number or Rural Route Number, City or Town, State) <u></u> | |
| 44. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | 45. SIGNATURE AND TITLE OF CERTIFIER <u></u> | | 46. LICENSE NUMBER <u>D36054</u> | |
| 47. DATE SIGNED (Month, Day, Year) <u>6/19/95</u> | | | | 48. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <u>Patrick Shanahan MD 120 SPERO RD S II CHESTERTOWN MD</u> | | 49. DATE FILED (Month, Day, Year) <u>JUN 21 '95</u> | |
| 50. REGISTRAR'S SIGNATURE <u>John Davidson-Randall</u> | | | | 51. 21620 | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 21885

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) Elizabeth Katherine Townsend | | | | 2. DATE OF DEATH MONTH DAY YEAR June 29, 1995 | | 3. TIME OF DEATH 1650 Hrs M | |
| 4. SOCIAL SECURITY NUMBER 215-20-0550 | | 5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 8. AGE (In yrs. last birthday) 79 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) July 17, 1915 | |
| 9a. FACILITY NAME (If not institution, give street and number) 326 Truslow Road (AT HOME) | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Chestertown | | 9c. COUNTY OF DEATH Queen Annes | |
| RESIDENCE OF DECEDENT | | | | | | | |
| 10a. STATE Maryland | | 10b. COUNTY Queen Annes | | 10c. CITY, TOWN OR LOCATION Chestertown | | 10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| 10e. STREET AND NUMBER 326 Truslow Road | | | | 10f. ZIP CODE 21620 | | 10g. CITIZEN OF WHAT COUNTRY? United States | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 11 College (1-4 or 5+) 11 | | | | 18a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Homemaker | | 16b. KIND OF BUSINESS/INDUSTRY Domestic / Own Home | |
| 17. FATHER'S NAME (First, Middle, Last) Edward Kinsey | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Elizabeth Valentine | | | |
| 19a. INFORMANT'S NAME (Type/Print) Edward Lee Townsend | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) Airy Hill Road, Chestertown, Maryland 21620 | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Chester Cemetery - July 2, 1995 | | DATE | | 20c. LOCATION — City or Town, State Chestertown, Maryland | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE William L. King Jr. | | | | 22. NAME AND ADDRESS OF FACILITY Fellows - Wells Funeral Home 413 West High Street - Chestertown, Maryland | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST a. DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): AS CVD IMMEDIATE | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER Ralph E. Libby, M.D. | | | | 29c. LICENSE NUMBER 205754 | | 29d. DATE SIGNED (Month, Day, Year) 7-3-95 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Ralph E. Libby, M.D., 204 Medical Center Rd., P.O. Box 458, Grasonville, MD 21638 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JUL 06 '95 | | | | 32. REGISTRAR'S SIGNATURE John Davidson-Randall | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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7 Kb.

95 21886

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | | | | |
|--|--|---|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) Walter A. L. Thompson | | | | 2. DATE OF DEATH MONTH DAY YEAR June 6, 1995 | | 3. TIME OF DEATH 1846P M | |
| 4. SOCIAL SECURITY NUMBER 089-26-4734 | | 5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 83 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) Dec. 16, 1911 | |
| 8. BIRTHPLACE (State or Foreign Country) Illinois | | | | 9a. FACILITY NAME (If not institution, give street and number) Kent & queen Anne's Hospital Inc. | | 9b. CITY, TOWN OR LOCATION OF DEATH Chestertown | |
| 9c. COUNTY OF DEATH Kent | | | | 10a. STATE Maryland | | | |
| 10b. COUNTY Kent | | | | 10c. CITY, TOWN OR LOCATION Chestertown | | | |
| 10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | | | 10e. STREET AND NUMBER 435 Teal Court, Heron Point | | | |
| 10f. ZIP CODE 21620 | | | | 10g. CITIZEN OF WHAT COUNTRY? USA | | | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES WWII | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 8 | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Physician | | 16b. KIND OF BUSINESS/INDUSTRY Medical | | | |
| 17. FATHER'S NAME (First, Middle, Last) Andrew H. Thompson | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Lillie Johnson | | | |
| 19a. INFORMANT'S NAME (Type/Print) Doris Reeves Thompson | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 435 Teal Court, Heron Point, Chestertown, Md. 21620 | | | |
| 20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Capital Crematory, June 7, 95 | | 20c. LOCATION — City or Town, State Dover, De. | | 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Doris B. Tillman</i> | |
| 22. NAME AND ADDRESS OF FACILITY Fellows - Wells Funeral Home 413 High St. Chestertown, Md. 21620 | | 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <i>acute pulmonary embolism</i> DUE TO (OR AS A CONSEQUENCE OF): b. <i>coronary heart failure</i> DUE TO (OR AS A CONSEQUENCE OF): c. <i>ischemic cardiomyopathy</i> DUE TO (OR AS A CONSEQUENCE OF): d. Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | | | DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/> | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. SIGNATURE AND TITLE OF CERTIFIER <i>John C. Seymour M.D.</i> | | 29c. LICENSE NUMBER D-13824 | | 29d. DATE SIGNED (Month, Day, Year) 6-6-95 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 122 Spear Rd. Chestertown, Md. 21620 John C. Seymour M.D. | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JUN 09 95 | | 32. REGISTRAR'S SIGNATURE <i>John Davidson-Randall</i> | | | | | |

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Amended #10e 7/12/95 MRT Montgomery City 95 21887

FOR
1 - STATE
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) FRED Joseph Williams | | | | 2. DATE OF DEATH MONTH July DAY 5 YEAR 95 | | 3. TIME OF DEATH 2:35A | |
| 4. SOCIAL SECURITY NUMBER 156-01-6188 | | 5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 78 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) March 14, 1917 | |
| 8. BIRTHPLACE (State or Foreign Country) New Jersey | | | | 9. COUNTY OF DEATH Montgomery | | | |
| 10a. STATE n/a | | | | 10b. COUNTY n/a | | 10c. CITY, TOWN OR LOCATION Washington, D.C. | |
| 10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | | | | | | |
| 11. STREET AND NUMBER 38 Argyle Terrace | | | | 12. ZIP CODE 20011 | | 13. CITIZEN OF WHAT COUNTRY? United States | |
| 14. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced | | | | 15. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES WW II | | | |
| 16. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | | | 17. RACE — American Indian, Black, White, etc. Specify: White | | | |
| 18. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 2 College (1-4 or 5+) 2 | | | | 19. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Mechanical Engineer | | | |
| 20. KIND OF BUSINESS/INDUSTRY Air Filtration Company | | | | | | | |
| 21. FATHER'S NAME (First, Middle, Last) Louis Williams | | | | 22. MOTHER'S NAME (First, Middle, Maiden Surname) Margaret Mignogna | | | |
| 23. INFORMANT'S NAME (Type/Print) Karen L. Williams (Niece) | | | | 24. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) Same as #10 | | | |
| 25. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 26. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) St. Gertrudes Cemetery 7-10 Colonia, NJ | | | |
| 27. SIGNATURE OF FUNERAL SERVICE LICENSEE [Signature] M00827 | | | | 28. NAME AND ADDRESS OF FACILITY Rapp Funeral Services, P.A. 933 Gist Ave, Silver Spring, MD 20910 | | | |
| 29. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. aspiration pneumonia DUE TO (OR AS A CONSEQUENCE OF): Approximate Interval Between Onset and Death hours Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | |
| 30. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | | | 31. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | |
| 32. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide | | | | 33. DATE OF INJURY (Month, Day, Year) 28b. TIME OF INJURY M 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO 28d. DESCRIBE HOW INJURY OCCURRED 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 34. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 35. SIGNATURE AND TITLE OF CERTIFIER [Signature] | | | | 36. LICENSE NUMBER 008740 | | 37. DATE SIGNED (Month, Day, Year) July 5-95 | |
| 38. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) John T. [Signature] 8218 W. 8th Ave | | | | | | | |
| 39. DATE FILED (Month, Day, Year) JUL 07 1995 | | | | 40. REGISTRAR'S SIGNATURE [Signature] | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 21888

ITEMS: 23 PART I, 27, PER DR. FILM G-726 8/22/95 t.t

FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|---|--|---|--|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last) William Otto Wirt | | | | 2. DATE OF DEATH MONTH June DAY 5 YEAR 1995 | | 3. TIME OF DEATH 03:25 a. M | |
| 4. SOCIAL SECURITY NUMBER 195-20-3876 | | 5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 67 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) November 22, 1927 | |
| 9a. FACILITY NAME (If not institution, give street and number) Naval Hospital | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Patuxent River | | 9c. COUNTY OF DEATH St. Mary's | |
| RESIDENCE OF DECEDENT | | | | | | | |
| 10a. STATE Maryland | | 10b. COUNTY St. Mary's | | 10c. CITY, TOWN OR LOCATION Lexington Park | | 10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| 10e. STREET AND NUMBER 310 Spruce Drive | | | | 10f. ZIP CODE 20653 | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Commissioned Officer | | 16b. KIND OF BUSINESS/INDUSTRY U.S. Navy/Defense | | | |
| 17. FATHER'S NAME (First, Middle, Last) William Otto Wirt | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Estella Thacker | | | |
| 19a. INFORMANT'S NAME (Type/Print) Marie Wirt | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 310 Spruce Drive, Lexington Park, Maryland 20653 | | | |
| 20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Arlington National Cemetery | | DATE | | 20c. LOCATION — City or Town, State Arlington, Virginia | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Edward N. Brinsfield, Jr.</i> Edward N. Brinsfield, Jr., M00052 | | | | 22. NAME AND ADDRESS OF FACILITY Brinsfield Funeral Home, P.A. 59 N. Washington St., Leonardtown, MD 20650-0279 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. SEVERE CORONARY ARTERY DISEASE DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST | | | | | | | Approximate Interval Between Onset and Death |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 6 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | | | 29. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER <i>William D. Boyd II</i> | | | | 29c. LICENSE NUMBER D14285 | | 29d. DATE SIGNED (Month, Day, Year) 6-5-95 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) William D. Boyd II, M.D., 17 Jefferson St., Leonardtown, Maryland 20650 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JUL 20 1995 | | | | 32. REGISTRAR'S SIGNATURE <i>John Davidson-Randall</i> | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 21889

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|--|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) HELEN ROSALIE WILSON | | | | 2. DATE OF DEATH MONTH DAY YEAR July 7 1995 | | 3. TIME OF DEATH 1:30 P M | |
| 4. SOCIAL SECURITY NUMBER 214-05-7443 | | 5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 78 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) OCT 20 1916 | |
| 8. BIRTHPLACE (State or Foreign Country) MARYLAND | | | | 9a. FACILITY NAME (If not institution, give street and number) MEMORIAL HOSPITAL | | 9b. CITY, TOWN OR LOCATION OF DEATH Cumberland | |
| 9c. COUNTY OF DEATH ALLEGANY | | | | 10a. STATE MARYLAND | | 10b. COUNTY ALLEGANY | |
| 10c. CITY, TOWN OR LOCATION CUMBERLAND | | | | 10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 10e. STREET AND NUMBER 12720 BEDFORD ROAD N.E. | |
| 10f. ZIP CODE 21502 | | | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | | 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced | |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: WHITE | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5 +) | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) HOUSE KEEPER | | 16b. KIND OF BUSINESS/INDUSTRY HOUSE KEEPER | |
| 17. FATHER'S NAME (First, Middle, Last) CHARLES F. KAISER | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) CLARA ASH | | | |
| 19a. INFORMANT'S NAME (Type/Print) DAVID WILSON | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) RFD#2 BOX#635 RIDGELEY, W.VA. 26753 | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) SUNSET CEMETERY JULY 10, 1995 | | 20c. LOCATION — City or Town, State CUMBERLAND MARYLAND | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Dale L. Merritt</i> | | | | 22. NAME AND ADDRESS OF FACILITY MERRITT-ADAMS FUNERAL HOME 404 DECATUR STREET CUMBERLAND MARYLAND | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | | | | | | | |
| a. RENAL FAILURE DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| b. CONGESTIVE HEART FAILURE DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| c. DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| d. DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | | | | |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | | | | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide | | | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | 28d. DESCRIBE HOW INJURY OCCURRED | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | 29b. SIGNATURE AND TITLE OF CERTIFIER <i>Guy Fiscus</i> | | 29c. LICENSE NUMBER D 12779 | |
| 29d. DATE SIGNED (Month, Day, Year) July 10, 1995 | | | | 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Guy Fiscus M.D. Memorial Hospital Medical Building Cumberland, MD 21502 | | | |
| 31. DATE FILED (Month, Day, Year) JUL 10 1995 | | | | 32. REGISTRAR'S SIGNATURE <i>John C. ...</i> | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

P.O. BOX 68766

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 21890

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|---|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) JULIUS OLIN WILHELM | | | | 2. DATE OF DEATH MONTH DAY YEAR July 5, 1995 | | 3. TIME OF DEATH 2:57 P M | |
| 4. SOCIAL SECURITY NUMBER 215-56-9142 | | 5. SEX 1 <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 88 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 16 FEBRUARY 1907 | |
| 9a. FACILITY NAME (If not institution, give street and number) MEMORIAL HOSPITAL | | | | 9b. CITY, TOWN OR LOCATION OF DEATH CUMBERLAND | | 9c. COUNTY OF DEATH ALLEGANY | |
| 10a. STATE MARYLAND | | | | 10b. COUNTY GARRETT | | 10c. CITY, TOWN OR LOCATION FROSTBURG | |
| 10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | 10e. STREET AND NUMBER ROUTE 2 BOX 619 | | | |
| 10f. ZIP CODE 21532 | | | | 10g. CITIZEN OF WHAT COUNTRY? USA | | | |
| 11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: WHITE | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 6 College (1-4 or 5+) College (1-4 or 5+) | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) FARMER | | 16b. KIND OF BUSINESS/INDUSTRY FARMING | | | |
| 17. FATHER'S NAME (First, Middle, Last) JOHN OLIN WILHELM | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) ADA GARLITZ | | | |
| 19a. INFORMANT'S NAME (Type/Print) BEATRICE W. OPEL | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 18218 NATIONAL PIKE, FROSTBURG, MD 21532 | | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) BLOCHER CEMETERY JULY 8, 1995 | | 20c. LOCATION — City or Town, State FROSTBURG, MARYLAND | | 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Douglas A. Hafner</i> | |
| 22. NAME AND ADDRESS OF FACILITY HAFER FROST MANSION FUNERAL HOME | | 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. ACUTE RESPIRATORY FAILURE DUE TO (OR AS A CONSEQUENCE OF): ASPIRATION PNEUMONIA DIABETIC COMP. | | Approximate Interval Between Onset and Death 3 DAYS 7 DAYS 7 days | | 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | 27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | |
| 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED | |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | 29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. SIGNATURE AND TITLE OF CERTIFIER <i>Dr. Dinesh Shah</i> | |
| 29c. LICENSE NUMBER D 23334 | | 29d. DATE SIGNED (Month, Day, Year) 7/7/95 7th JULY 1995 | | 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Dr. Dinesh Shah-Johnson Heights Medical building-Cumberland, MD 21502 | | 31. DATE FILED (Month, Day, Year) JUL 10 1995 | |
| 32. REGISTRAR'S SIGNATURE <i>Paula Randall</i> | | | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 21891

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|---|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) KATHERINE B WINEOW | | | | 2. DATE OF DEATH JULY 1 DAY 1995 | | 3. TIME OF DEATH 08:50A | |
| 4. SOCIAL SECURITY NUMBER 214 05 8316 | | 5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | 6. AGE (In yrs. last birthday) 91 YRS. | 7. DATE OF BIRTH (Month, Day, Year) July 2, 1903 | | 8. BIRTHPLACE (State or Foreign Country) West Virginia | |
| 9a. FACILITY NAME (If not institution, give street and number) MEMORIAL HOSPITAL | | | | 9b. CITY, TOWN OR LOCATION OF DEATH CUMBERLAND | | 9c. COUNTY OF DEATH ALLEGANY | |
| RESIDENCE OF DECEDENT | | | | | | | |
| 10a. STATE MARYLAND | | 10b. COUNTY ALLEGANY | | 10c. CITY, TOWN OR LOCATION CUMBERLAND | | 10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 10e. STREET AND NUMBER 552 N. MECHANIC STREET | | | | 10f. ZIP CODE 21502 | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: WHITE | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) UNKNOWN | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) SALES CLERK | | 16b. KIND OF BUSINESS/INDUSTRY RETAIL STORE | | | |
| 17. FATHER'S NAME (First, Middle, Last) WILLIAM S. MOORE | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) ANNA LINABURG | | | |
| 19a. INFORMANT'S NAME (Type/Print) MELBA TEWELL | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) ROUTE 3, BOX 308 - BEDFORD, PA 15522 | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) SUNSET MEMORIAL PARK 7/3/95 | | 20c. LOCATION — City or Town, State CUMBERLAND, MD | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Wendy G. Upchurch</i> | | | | 22. NAME AND ADDRESS OF FACILITY GEORGE-UPCHURCH FUNERAL HOME, P.A. 202 GREENE ST., CUMBERLAND, MD 21502 | | | |
| 23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | | a. Cerebrovascular Accident DUE TO (OR AS A CONSEQUENCE OF): | | | | | |
| | | b. Cerebral Atherosclerosis DUE TO (OR AS A CONSEQUENCE OF): | | | | | |
| | | c. DUE TO (OR AS A CONSEQUENCE OF): | | | | | |
| | | d. DUE TO (OR AS A CONSEQUENCE OF): | | | | | |
| Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input checked="" type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| | | 28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28e. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i> | | | | 29c. LICENSE NUMBER D 19318 | | 29d. DATE SIGNED (Month, Day, Year) July 2nd 1995 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) DR VIMALA RANJITHAN 517 OLDTOWN ROAD CUMBERLAND MD 21502 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JUL 05 1995 | | | | 32. REGISTRAR'S SIGNATURE <i>[Signature]</i> | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|--|---|--|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) William Grier Willis | | | | 2. DATE OF DEATH MONTH DAY YEAR June 2, 1995 | | 3. TIME OF DEATH 1030 hrs M | |
| 4. SOCIAL SECURITY NUMBER 192-18-3135 | | 5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F | 6. AGE (In yrs. last birthday) 85 YRS. | 7. DATE OF BIRTH (Month, Day, Year) August 18, 1909 | | 8. BIRTHPLACE (State or Foreign Country) Pennsylvania | |
| 9a. FACILITY NAME (If not institution, give street and number) Kent & Queen Annes Hospital | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Chestertown | | 9c. COUNTY OF DEATH Kent | |
| 10a. STATE Maryland | | | | 10b. COUNTY Kent | | 10c. CITY, TOWN OR LOCATION Chestertown | |
| 10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | | | 10e. STREET AND NUMBER 501 Campus Avenue - 214 Heron Point | | 10f. ZIP CODE 21620 | |
| 10g. CITIZEN OF WHAT COUNTRY? United States | | | | 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | |
| 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | | | 14. RACE — American Indian, Black, White, etc. Specify: White | | 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 5+ | |
| 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Professor / Administrator | | | | 16b. KIND OF BUSINESS/INDUSTRY Education | | 17. FATHER'S NAME (First, Middle, Last) William Wishart Willis | |
| 18. MOTHER'S NAME (First, Middle, Maiden Surname) Ora Forsythe | | | | 19a. INFORMANT'S NAME (Type/Print) Mrs. Martha Dale | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 221 Lenoir Avenue, Wayne, Pennsylvania 19807 | |
| 20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Capitol Crematory - June 3, 1995 | | 20c. LOCATION — City or Town, State Dover, Delaware | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE William L. King Jr. | | | | 22. NAME AND ADDRESS OF FACILITY Fellows - Wells Funeral Home 413 West High Street - Chestertown, Maryland 21620 | | 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <u>Acute Respiratory Failure</u> DUE TO (OR AS A CONSEQUENCE OF): b. <u>Chronic Obstructive Lung Disease</u> DUE TO (OR AS A CONSEQUENCE OF): c. _____ DUE TO (OR AS A CONSEQUENCE OF): d. _____ Approximate Interval Between Onset and Death 16 Yrs | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. _____ _____ | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | |
| 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, term, street, factory, office building, etc. (Specify) | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. SIGNATURE AND TITLE OF CERTIFIER John L. Davidson | |
| 29c. LICENSE NUMBER D-13824 | | | | 29d. DATE SIGNED (Month, Day, Year) June 2, 1995 | | 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) | |
| 31. DATE FILED (Month, Day, Year) JUN 05 '95 | | | | 32. REGISTRAR'S SIGNATURE John Davidson-Randall | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 21893

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | |
|---|--|--|--|---|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) Frank Elmer Wersten | | | | 2. DATE OF DEATH MONTH DAY YEAR June 24, 1995 | | | | 3. TIME OF DEATH 6:35 p. M | |
| 4. SOCIAL SECURITY NUMBER 218-07-1456 | | 5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 88 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) September 2, 1906 | | 8. BIRTHPLACE (State or Foreign Country) Maryland | |
| 9a. FACILITY NAME (If not institution, give street and number) 325 2nd Street (AT HOME) | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Crumpton | | | | 9c. COUNTY OF DEATH Queen Annes | |
| 10a. STATE Maryland | | | | 10b. COUNTY Queen Annes | | 10c. CITY, TOWN OR LOCATION Crumpton | | | |
| 10e. STREET AND NUMBER 325 2nd Street | | | | 10f. ZIP CODE 21628 | | 10g. CITIZEN OF WHAT COUNTRY? United States | | | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White | | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 3 College (1-4 or 5+) 3 | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Painter / Carpenter | | 16b. KIND OF BUSINESS/INDUSTRY Building Industry | | | | | |
| 17. FATHER'S NAME (First, Middle, Last) William Elmer Wersten | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Dora (Maiden Name Unknown) | | | | | |
| 19a. INFORMANT'S NAME (Type/Print) Susie Elizabeth Wersten | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 325 2nd Street, Crumpton, Maryland 21628 | | | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Crumpton Cemetery - June 27, 1995 | | 20c. LOCATION — City or Town, State Crumpton, Maryland | | | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE William L. King Jr | | | | 22. NAME AND ADDRESS OF FACILITY Fellows Funeral Homes, P.A. Cypress, Millington, Maryland 21651 | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Congestive Heart Failure DUE TO (OR AS A CONSEQUENCE OF): b. COAD — Myocardial Infarction DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | | | Approximate Interval Between Onset and Death Weeks | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Advanced Alzheimer's Disease | | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | | | | | | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. SIGNATURE AND TITLE OF CERTIFIER C. GoHfried Baumann, M.D. | | 29c. LICENSE NUMBER D00354 | | 29d. DATE SIGNED (Month, Day, Year) 6/27/95 | | | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type/Print) C. GoHfried Baumann, M.D. Chestertown, Md. 21620 | | | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JUN 27 '95 | | 32. REGISTRAR'S SIGNATURE John Davidson-Bondell | | | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 21894

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|---|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) Christine Edna Waid | | | | 2. DATE OF DEATH MONTH July DAY 7 YEAR 1995 | | 3. TIME OF DEATH 9:38 P. M | |
| 4. SOCIAL SECURITY NUMBER 578-40-2266 | | 5. SEX 1 <input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 65 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 12/23/1929 | |
| 8a. FACILITY NAME (If not institution, give street and number) Physicians Memorial Hospital | | | | 8b. CITY, TOWN OR LOCATION OF DEATH LaPlata | | 8c. COUNTY OF DEATH Charles | |
| RESIDENCE OF DECEDENT | | | | | | | |
| 10a. STATE Maryland | | 10b. COUNTY Charles | | 10c. CITY, TOWN OR LOCATION Waldorf | | 10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 10e. STREET AND NUMBER 3008 Gallery Place | | | | 10f. ZIP CODE 20602 | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 12 | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Home Maker | | 16b. KIND OF BUSINESS/INDUSTRY At Home | |
| 17. FATHER'S NAME (First, Middle, Last) John Ross | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Thelma Cassell | | | |
| 19a. INFORMANT'S NAME (Type/Print) Roger W. Springer | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2900 Jackson Court, Waldorf, Md. 20602 | | | |
| 20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 6 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Resurrection Cemetery 7/11 | | 20c. LOCATION — City or Town, State Clinton, Md. | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>L C Echols</i> M-00174 | | | | 22. NAME AND ADDRESS OF FACILITY AREHART-ECHOLS FUNERAL HOME, INC. P.O. Box 567, La Plata, Md. 20646 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Adult Respiratory Distress Syndrome DUE TO (OR AS A CONSEQUENCE OF): Aspiration pneumonia DUE TO (OR AS A CONSEQUENCE OF): Chronic obstructive pulmonary disease DUE TO (OR AS A CONSEQUENCE OF): Hypovolemic and septic shock Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST Chronic renal failure, Metastatic adenocarcinoma. PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 6 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| 28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28d. DESCRIBE HOW INJURY OCCURRED | | | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER <i>Sanjeeb K. Mishra</i> | | | | 29c. LICENSE NUMBER D-23021 | | 29d. DATE SIGNED (Month, Day, Year) 7/8/95 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Sanjeeb K. Mishra MD 7C Post Office Road Cenna Center Waldorf, Md. 20602 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JUL 10 1995 | | | | 32. REGISTRAR'S SIGNATURE <i>John Davidson Randall</i> | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 21895

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | | | | |
|--|--|--|--|---|--|--|---|
| 1. DECEDENT'S NAME (First, Middle, Last) JOHN VIRGIL WAITS JR. | | | | 2. DATE OF DEATH MONTH DAY YEAR JULY 8 1995 | | 3. TIME OF DEATH 14:47 M | |
| 4. SOCIAL SECURITY NUMBER 578-24-3623 | | 5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 71 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) JAN. 24 1924 | |
| 8. BIRTHPLACE (State or Foreign Country) Georgia | | | | 9a. FACILITY NAME (If not institution, give street and number) MEMORIAL HOSPITAL | | 9b. CITY, TOWN OR LOCATION OF DEATH CUMBERLAND | |
| 9c. COUNTY OF DEATH ALLEGANY | | | | 10a. STATE D.C. | | 10b. COUNTY Washington | |
| 10c. CITY, TOWN OR LOCATION Washington | | | | 10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | 10e. STREET AND NUMBER 3608 VAN NESS STREET N.W. | |
| 10f. ZIP CODE 20008 | | | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | | 11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: WHITE | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (10-12) 12+ College (1-4 or 5+) 2 | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) NEWSPAPER EXECUTIVE | | 16b. KIND OF BUSINESS/INDUSTRY WASHINGTON POST NEWSPAPER | |
| 17. FATHER'S NAME (First, Middle, Last) JOHN VIRGIL WAITS SR. | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) CLAIRE SNEAD | | | |
| 19a. INFORMANT'S NAME (Type/Print) EILEEN WAITS | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3608 VAN NESS STREET N.W. WASHINGTON, D.C. 20008 | | | |
| 20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) CUMBERLAND CREMATORY JULY 9 1995 CUMBERLAND MARYLAND | | 20c. LOCATION — City or Town, State | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Dale L. Merritt</i> | | | | 22. NAME AND ADDRESS OF FACILITY MERRITT-ADAMS FUNERAL HOME 404 DECATUR STREET CUMBERLAND MARYLAND | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. INTRAVENTRICULAR HEMORRHAGE DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | | Approximate Interval Between Onset and Death 3 DAYS |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. HYPERTENSION | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | | | | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER <i>Robustiano Barrera, J. MD</i> | | | | 29c. LICENSE NUMBER D 14865 | | 29d. DATE SIGNED (Month, Day, Year) JULY 9, 1995 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) DR. ROBUSTIANO BARRERA, MEMORIAL MEDICAL BLDG., CUMBERLAND, MD 21502 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JUL 10 1995 | | | | 32. REGISTRAR'S SIGNATURE <i>John Thomas Randall</i> | | | |

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 21896

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) William E Mory Wright | | | | 2. DATE OF DEATH MONTH DAY YEAR July 5, 1995 | | 3. TIME OF DEATH 8:00 A M | |
| 4. SOCIAL SECURITY NUMBER 199-07-2735 | | 5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 75 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) Sept. 18, 1919 | |
| 8. BIRTHPLACE (State or Foreign Country) Maryland | | | | 9a. FACILITY NAME (If not institution, give street and number) Greater Balto. Medical Center | | 9b. CITY, TOWN OR LOCATION OF DEATH Towson | |
| 9c. COUNTY OF DEATH Baltimore | | | | 10a. STATE Maryland | | 10b. COUNTY Baltimore | |
| 10c. CITY, TOWN OR LOCATION Parkton | | | | 10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 10e. STREET AND NUMBER 17105 York Road, | |
| 10f. ZIP CODE 21120 | | | | 10g. CITIZEN OF WHAT COUNTRY? USA | | 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 9 College (1-4 or 5+) 9 | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Heavy Equipment Mechanic | | 16b. KIND OF BUSINESS/INDUSTRY Construction/Paving | |
| 17. FATHER'S NAME (First, Middle, Last) William Odas Wright | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Mary E. Smith | | | |
| 19a. INFORMANT'S NAME (Type/Print) B. Irene Wright | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 17105 York Rd., Parkton, Md. 21120 | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Dulaney Valley Mem. 7/8/95 | | 20c. LOCATION — City or Town, State Timonium, Md. | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>J.J. Hartenstein</i> | | | | 22. NAME AND ADDRESS OF FUNERAL HOME J.J. Hartenstein Mortuary 24 Second St., New Freedom, Pa. 17349 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Arteriosclerotic Cardio Renal Vascular Disease</i> DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | 25. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | |
| 27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide | | | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY | |
| 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | 28d. DESCRIBE HOW INJURY OCCURRED | | | |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER <i>Charles F. O'Donnell, M.D.</i> | | | | 29c. LICENSE NUMBER D-OCME | | 29d. DATE SIGNED (Month, Day, Year) 7-5-95 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Charles F. O'Donnell, M.D. 111 Hamlet Hill Rd. Baltimore | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JUL 18 1995 | | | | 32. REGISTRAR'S SIGNATURE <i>John Davidson-Randall</i> | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 21897

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) Harriet Lucinda Young | | | | 2. DATE OF DEATH MONTH DAY YEAR May 18, 1995 | | 3. TIME OF DEATH 7:15 A M | |
| 4. SOCIAL SECURITY NUMBER 220-20-2660 | | 5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 67 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) Mar 5, 1928 | |
| 9a. FACILITY NAME (If not institution, give street and number) St. Mary's Hospital | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Leonardtown | | 9c. COUNTY OF DEATH St. Mary's | |
| 10a. STATE Maryland | | 10b. COUNTY St. Mary's | | 10c. CITY, TOWN OR LOCATION Avenue | | 10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| 10e. STREET AND NUMBER 103 Oakley Road | | | | 10f. ZIP CODE 20609 | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: Black | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (9-12) 2 College (1-4 or 5+) 2 years | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Teacher's Aide | | 16b. KIND OF BUSINESS/INDUSTRY County Government | | | |
| 17. FATHER'S NAME (First, Middle, Last) Jared Jameson | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Fanny Wilson | | | |
| 19a. INFORMANT'S NAME (Type/Print) Vivian N. Herbert | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 103 Oakley Road, Avenue, Maryland 20609 | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) All Saints Cemetery 5/22/95 | | 20c. LOCATION — City or Town, State Avenue, Maryland | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Michael L. Gardiner</i> | | | | 22. NAME AND ADDRESS OF FACILITY Mattingley-Gardiner Funeral Home, P.A. P.O. Box 270, Leonardtown, Maryland 20650 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | | a. <i>Respiratory Failure</i> 6-8 hours | | | | | |
| | | b. <i>2 to pneumonia</i> | | | | | |
| | | c. <i>and sepsis (urosepsis)</i> | | | | | |
| | | d. | | | | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| | | 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER <i>KMHA</i> | | | | 29c. LICENSE NUMBER <i>D26206</i> | | 29d. DATE SIGNED (Month, Day, Year) <i>5/19/95</i> | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Kiran Mehta, M.D. Shanti Medical Center, Leonardtown, Maryland 20650 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) MAY 19 1995 | | | | REGISTRAR'S SIGNATURE <i>John Davidson Randall</i> | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

P.O. BOX 68760

DIVISION OF VITAL RECORDS

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 21898

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|--|--|--|--|--|---|
| 1. DECEDENT'S NAME (First, Middle, Last) LENORA L ouise ALBERT | | | | 2. DATE OF DEATH MONTH JULY DAY 5 YEAR 1995 | | 3. TIME OF DEATH 1000 P^M | |
| 4. SOCIAL SECURITY NUMBER 214-26-6915 | | 5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 67 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) Feb. 20, 1928 | |
| 8. BIRTHPLACE (State or Foreign Country) Maryland | | | | 9a. FACILITY NAME (If not institution, give street and number) CITIZENS NURSING HOME | | 9b. CITY, TOWN OR LOCATION OF DEATH HAVRE DE GRACE | |
| 9c. COUNTY OF DEATH HARFORD | | | | 10a. STATE Maryland | | 10b. COUNTY Harford | |
| 10c. CITY, TOWN OR LOCATION Aberdeen | | | | 10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 10e. STREET AND NUMBER 16 E. Aztec Street | |
| 10f. ZIP CODE 21001 | | | | 10g. CITIZEN OF WHAT COUNTRY? USA | | 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 6 College (1-4 or 5+) College | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Homemaker | | 16b. KIND OF BUSINESS/INDUSTRY | |
| 17. FATHER'S NAME (First, Middle, Last) Leonard John Owens | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Louise Orr | | | |
| 19a. INFORMANT'S NAME (Type/Print) Cynthia Ross | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 470 Battery Drive, Havre de Grace, MD 21078 | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Harford Memorial Gardens 7/10 | | 20c. LOCATION — City or Town, State Aberdeen, Maryland | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Becky A. Yunker | | | | 22. NAME AND ADDRESS OF FACILITY Mitchell-Smith Funeral Home, P.A. Havre de Grace, MD 21078-3197 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Cerebrovascular accident Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST Arteriosclerotic Cardiovascular disease Seizure disorder Diabetes | | | | | | | Approximate Interval Between Onset and Death |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | | | | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/> | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide | | | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | |
| 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | 28d. DESCRIBE HOW INJURY OCCURRED | | | |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER J. Lee M.D. | | | | 29c. LICENSE NUMBER D20661 | | 29d. DATE SIGNED (Month, Day, Year) 7/6/95 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) J. J. LEEMD. 307 S. Union Ave. Havre de Grace MD | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JUL 07 1995 | | | | 32. REGISTRAR'S SIGNATURE John H. ... | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 21899

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|---|--|--|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) Barry Barnett | | | | 2. DATE OF DEATH MONTH June DAY 8 YEAR 1995 | | 3. TIME OF DEATH 9:20 A | |
| 4. SOCIAL SECURITY NUMBER 579-90-6627 | | 5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 34 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) JULY 16, 1960 | |
| 8a. FACILITY NAME (If not institution, give street and number) PRINCE GEORGE HOSPITAL | | | | 8b. CITY, TOWN OR LOCATION OF DEATH CHEVERLY | | 8c. COUNTY OF DEATH PG | |
| RESIDENCE OF DECEDENT | | | | | | | |
| 10a. STATE DC | | 10b. COUNTY | | 10c. CITY, TOWN OR LOCATION WASHINGTON | | 10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | |
| 10e. STREET AND NUMBER 1393 CONGRESS ST. SE #2 | | | | 10f. ZIP CODE 20032 | | 10g. CITIZEN OF WHAT COUNTRY? USA | |
| 11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: NO | | 14. RACE — American Indian, Black, White, etc. Specify: BLACK | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 10TH College (1-4 or 5+) UNOBTAINABLE | | 15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) UNOBTAINABLE | | 15b. KIND OF BUSINESS/INDUSTRY UNOBTAINABLE | | | |
| 17. FATHER'S NAME (First, Middle, Last) JOHN LEWIS | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) CHARLOTTE MONTGOMERY | | | |
| 19a. INFORMANT'S NAME (Type/Print) CHARLOTTE DIGGS | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1393 CONGRESS ST. SE #2 WASHINGTON, DC 20032 | | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) HARMONY MEMORIAL PARK 6/13/95 LANDOVER, MD | | 20c. LOCATION — City or Town, State | | 20d. DATE | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i> | | | | 22. NAME AND ADDRESS OF FACILITY ROBERT G. MASON FUNERAL HOME, INC 1661 GOOD HOPE ROAD SE WASHINGTON, DC 20020 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Multiple injuries DUE TO (OR AS A CONSEQUENCE OF): Approximate Interval Between Onset and Death: 17 days Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST: a. DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> OOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide | | | | 28a. DATE OF INJURY (Month, Day, Year) May 22, 1995 | | 28b. TIME OF INJURY 1230 PM | |
| 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | 28d. DESCRIBE HOW INJURY OCCURRED Bicycle - car impact | | | |
| 28e. PLACE OF INJURY — At home, term, street, factory, office building, etc. (Specify) Livingston & Oxon Hill Road, Oxon Hill, Prince Georges, Md | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER <i>Augusto P. Rodriguez M.D.</i> | | | | 29c. LICENSE NUMBER A21230 | | 29d. DATE SIGNED (Month, Day, Year) June 8, 1995 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Augusto P. Rodriguez MD 5009 Layburn Ct. Cp Spr. Md 20748 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JUN 27 1995 | | | | 32. REGISTRAR'S SIGNATURE <i>John Davidson Randall</i> | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

P.O. BOX 68760

DIVISION OF VITAL RECORDS

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95 21900

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | | | | | |
|--|--|---|--|--|--|---|--|---|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) Nancy P. Brady | | | | 2. DATE OF DEATH MONTH DAY YEAR June 25, 1995 | | | | 3. TIME OF DEATH 1:42 A. M | | | | | |
| 4. SOCIAL SECURITY NUMBER 578-12-1984 | | 5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 78 YRS. | | IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. | | 7. DATE OF BIRTH (Month, Day, Year) March 25, 1917 | | 8. BIRTHPLACE (State or Foreign Country) Washington, D.C. | | | |
| 9a. FACILITY NAME (If not institution, give street and number) 940 Caravan Trail | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Owings | | | | 9c. COUNTY OF DEATH Calvert | | | | | |
| RESIDENCE OF DECEDENT | | | | | | | | | | | | | |
| 10a. STATE Maryland | | 10b. COUNTY Calvert | | 10c. CITY, TOWN OR LOCATION Owings | | | | 10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | | |
| 10e. STREET AND NUMBER 940 Caravan Trail | | | | 10f. ZIP CODE 20736 | | | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | | | | | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | | | 14. RACE — American Indian, Black, White, etc. Specify: White | | | | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 12 | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Copy Holder | | | | 16b. KIND OF BUSINESS/INDUSTRY U.S. Navy Oceanographic Off. | | | | | |
| 17. FATHER'S NAME (First, Middle, Last) Dominic Petrello | | | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Albina Scagnelli | | | | | | | |
| 19a. INFORMANT'S NAME (Type/Print) Nancy B. Bradley | | | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 940 Caravan Trail Owings, Maryland 20736 | | | | | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Cedar Hill Cemetery 6/28/95 | | | | 20c. LOCATION — City or Town, State Suitland, Maryland | | | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Robert P. Kalas | | | | 22. NAME AND ADDRESS OF FACILITY George P. Kalas Funeral Home 6160 Oxon Hill Rd. Oxon Hill, Md. 20745 | | | | | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Generalized Metastasis due to Colon Cancer Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST b. Colon Impacted Stenosis c. Stenosis of the Colon Type II d. Approximate Interval Between Onset and Death 15 yr 25 yr | | | | | | | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 6 <input type="checkbox"/> Could not be determined | | | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | 28d. DESCRIBE HOW INJURY OCCURRED | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | 29b. SIGNATURE AND TITLE OF CERTIFIER Benjamin S. Yeckon MD | | | | 29c. LICENSE NUMBER DO 9451 | | 29d. DATE SIGNED (Month, Day, Year) 6-25-95 | | 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) BENJAMIN S. YECKON MD 6106 OLD SILVER HILL RD. FORT WASHINGTON MD | |
| 31. DATE FILED (Month, Day, Year) JUN 26 1995 | | | | 32. REGISTRAR'S SIGNATURE John A. Davidson | | | | | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|---|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) CHARLES DEXTER BROWN | | | | 2. DATE OF DEATH MONTH JUNE DAY 21 YEAR 95 | | 3. TIME OF DEATH 1:42 P.M. | |
| 4. SOCIAL SECURITY NUMBER 213-80-5897 | | 5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 34 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) JANUARY 22, 1961 | |
| 8. BIRTHPLACE (State or Foreign Country) WASHINGTON D.C. | | | | 9. FACILITY NAME (If not institution, give street and number) 495 EAST OF CONN AVE | | 10. CITY, TOWN OR LOCATION OF DEATH MONTGOMERY | |
| RESIDENCE OF DECEDENT | | | | | | | |
| 10a. STATE MARYLAND | | 10b. COUNTY PRINCE GEORGES | | 10c. CITY, TOWN OR LOCATION LANDOVER HILLS | | 10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | |
| 10e. STREET AND NUMBER 7304 PARKWOOD STREET | | | | 10f. ZIP CODE 20784 | | 10g. CITIZEN OF WHAT COUNTRY? USA | |
| 11. MARITAL STATUS 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: BLACK | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) College | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) DRIVER | | 16b. KIND OF BUSINESS/INDUSTRY GOVERNMENT | | | |
| 17. FATHER'S NAME (First, Middle, Last) CHARLES S. BROWN | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) WILMA WILLIS | | | |
| 19a. INFORMANT'S NAME (Type/Print) WILMA WILLIS BROWN | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9006 LOCKWOOD AVE FORT WASHINGTON, MD 20744 | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) CHURCH CEMETERY | | 20c. LOCATION — City or Town, State CARSWELL COUNTY, N.C. | | 20d. DATE | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Shawana L. Braxton</i> | | | | 22. NAME AND ADDRESS OF FACILITY J.B. JENKINS FUNERAL HOME 7474 LANDOVER ROAD LANDOVER, MD 20785 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Multiple Injuries</i> | | | | | | | |
| DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | | |
| DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED? <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | | | | |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | | | | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) ROADWAY | | | | | |
| 27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input checked="" type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 6 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) 6/21/95 | | 28b. TIME OF INJURY 1343pM | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED motor vehicle collision | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) street | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) 495 near Conn. Ave Mont Co Md | | | |
| 29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER <i>Dennis J. Chute MD</i> | | | | 29c. LICENSE NUMBER O.C.M.E. | | 29d. DATE SIGNED (Month, Day, Year) JUNE 22, 1995 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) DENNIS J. CHUTE, MD 111 Penn Street, Baltimore, Maryland 21201 | | | | | | | |
| 31. DATE SIGNED (Month, Day, Year) JUN 26 1995 | | 32. REGISTRAR'S SIGNATURE <i>John A. ...</i> | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 21902

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|--|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) BARBARA BOWERSOX | | | | 2. DATE OF DEATH MONTH JUNE DAY 22 YEAR 1995 | | 3. TIME OF DEATH 8:50 p m | |
| 4. SOCIAL SECURITY NUMBER 220-40-6860 | | 5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 53 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) July 30, 1941 | |
| 9a. FACILITY NAME (If not institution, give street and number) 13114 13th Street | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Bowie | | 9c. COUNTY OF DEATH Prince George's | |
| 10a. STATE MD | | 10b. COUNTY Prince George's | | 10c. CITY, TOWN OR LOCATION Bowie | | 10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 10a. STREET AND NUMBER 13114 13th Street | | | | 10f. ZIP CODE 20715 | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) | | 15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Homemaker | | 16b. KIND OF BUSINESS/INDUSTRY Private | | | |
| 17. FATHER'S NAME (First, Middle, Last) Kirby Wood | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Eula Peters | | | |
| 19a. INFORMANT'S NAME (Type/Print) Kenneth Bowersox | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13114 13th St. Bowie, MD. 20715 | | | |
| 20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Chesapeake Crematory Jun 24 Beltsville, MD | | 20c. LOCATION — City or Town, State | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Shawana L. Braxton</i> | | | | 22. NAME AND ADDRESS OF FACILITY J.B. Jenkins Funeral Home 7474 Landover Rd. Landover, MD 20785 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Metastatic colon cancer</i> DUE TO (OR AS A CONSEQUENCE OF): Approximate Interval Between Onset and Death: 7 years | | | | | | | |
| Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | |
| 27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28d. DESCRIBE HOW INJURY OCCURRED | | | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | 28e. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | |
| 29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER <i>Augusto P. Rodriguez MD</i> | | | | 29c. LICENSE NUMBER A21230 | | 29d. DATE SIGNED (Month, Day, Year) Jun 23, 1995 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Augusto P. Rodriguez MD, 5009 Rayburn Ct Sp, MD 20748 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JUN 26 1995 | | | | 32. REGISTRAR'S SIGNATURE <i>John Davidson Randall</i> | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician.

THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 21903

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|--|--|---|--|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last) LEON BRISBANE | | | | 2. DATE OF DEATH MONTH JUNE DAY 28 YEAR 1995 | | 3. TIME OF DEATH 7:15 M | |
| 4. SOCIAL SECURITY NUMBER 219-74-9298 | | 5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 32 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) Oct. 22, 1962 | |
| 9a. FACILITY NAME (If not institution, give street and number) Greater Laurel Beltsville Hospital | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Laurel | | 9c. COUNTY OF DEATH Prince George's | |
| 10a. STATE MD | | 10b. COUNTY Prince George's | | 10c. CITY, TOWN OR LOCATION Laurel | | 10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 10e. STREET AND NUMBER 8907 BoxSoid Park | | | | 10f. ZIP CODE 20788 | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 11. MARITAL STATUS 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: Black | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) N/A College (1-4 or 5+) N/A | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Unemployed/ Disabled | | 16b. KIND OF BUSINESS/INDUSTRY N/A | | | |
| 17. FATHER'S NAME (First, Middle, Last) Herbert Brisbane | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Mary Walker | | | |
| 19a. INFORMANT'S NAME (Type/Print) Maggie Brisbane | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7816 Dellwood Ave. Glenarden, MD. 20706 | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Harmony Memorial Park | | DATE 95 | | 20c. LOCATION — City or Town, State Landover, MD. | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Juanana L. Braxton | | | | 22. NAME AND ADDRESS OF FACILITY J.B. Jenkins Funeral Home 7474 Landover Rd. Landover, MD 20785 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → CARDIAC ARREST DUE TO (OR AS A CONSEQUENCE OF): CARDIAC ENLARGEMENT DUE TO (OR AS A CONSEQUENCE OF): BRAIN TUMOR DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST | | | | | | | Approximate Interval Between Onset and Death |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | | | | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER Neil A. Meade | | | | 29c. LICENSE NUMBER D19220 | | 29d. DATE SIGNED (Month, Day, Year) 6-28-95 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Neil A. Meade 9811 Mallard Drive Laurel Md 20708 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JUL 08 1995 | | | | 32. REGISTRAR'S SIGNATURE Juanita Sanchez-Rodriguez | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | | | |
|---|--|--|--|---|--|--|---|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) TERESA M. BUENA | | | | 2. DATE OF DEATH MONTH DAY YEAR JULY 3, 1995 | | 3. TIME OF DEATH 8:52P M | | | | | |
| 4. SOCIAL SECURITY NUMBER 577-52-2877 | | 5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 76 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 10/20/18 | | 8. BIRTHPLACE (State or Foreign Country) Philippine Is. | | | |
| 9a. FACILITY NAME (If not institution, give street and number) 611 MAURY AVE. | | | | 9b. CITY, TOWN OR LOCATION OF DEATH OXON HILL | | | 9c. COUNTY OF DEATH PRINCE GEORGE | | | | |
| 10a. STATE Maryland | | 10b. COUNTY Prince George | | 10c. CITY, TOWN OR LOCATION Oxon Hill | | | 10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | |
| 10e. STREET AND NUMBER 611 Maury Ave. | | | | 10f. ZIP CODE 20745 | | 10g. CITIZEN OF WHAT COUNTRY? USA | | | | | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | | 14. RACE — American Indian, Black, White, etc. Specify: Filipino | | | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 5+ | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Registered Nurse | | 16b. KIND OF BUSINESS/INDUSTRY Nursing | | | | | | | |
| 17. FATHER'S NAME (First, Middle, Last) Hilario Mendez | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Maria Roloan | | | | | | | |
| 19a. INFORMANT'S NAME (Type/Print) Loretta A. Buena | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5410 Conn. Ave. N.W. Apt. 209 Washington, D.C. 20015 | | | | | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Arlington Nat. Cemetery 7/11/95 | | DATE 7/11/95 | | 20c. LOCATION — City or Town, State Arlington, Va. | | | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>George P. Kalas</i> | | | | 22. NAME AND ADDRESS OF FACILITY George P. Kalas Funeral Home 6160 Oxon Hill Rd. Oxon Hill, Md. 20745 | | | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <u>ATHROSCLECTIC CARDIOVASCULAR DISEASE</u> DUE TO (OR AS A CONSEQUENCE OF): b. _____ DUE TO (OR AS A CONSEQUENCE OF): c. _____ DUE TO (OR AS A CONSEQUENCE OF): d. _____ Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST | | | | | | | | Approximate Interval Between Onset and Death | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/> <u>Insufficient</u> | | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> OOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED | | | |
| 28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| 29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER <i>MaryAnn A. Kores</i> | | | | 29c. LICENSE NUMBER O.C.M.E. | | 29d. DATE SIGNED (Month, Day, Year) July 4, 1995 | | | | | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) MARYANN A. KORES 111 Penn Street, Baltimore, Maryland 21201 | | | | | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JUL 07 1995 | | | | 32. REGISTRAR'S SIGNATURE <i>John A. Davidson</i> | | | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Pages 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 21905

ITEMS: 23 PART I, 27, PER MEO FILM G-725 7/31/95 t.t

1 -
FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | |
|--|--|---|--|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last) RHONDA RENETTA BOWIE | | | 2. DATE OF DEATH MONTH DAY YEAR JUNE 30, 1995 | | 3. TIME OF DEATH 13:30 P M |
| 4. SOCIAL SECURITY NUMBER 578-96-0306 | 5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | 6. AGE (In yrs. last birthday) 32 YRS. | 7. DATE OF BIRTH (Month, Day, Year) SEP 3, 1962 | 8. BIRTHPLACE (State or Foreign Country) Georgia | |
| 9a. FACILITY NAME (If not institution, give street and number) 6577 HILMAN DR. | | | 9b. CITY, TOWN OR LOCATION OF DEATH Forestville | | 9c. COUNTY OF DEATH PRINCE GEORGES |
| 10a. STATE Maryland | | | 10b. COUNTY Prince Georges | | 10c. CITY, TOWN OR LOCATION Forestville |
| 10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | 10e. STREET AND NUMBER 6577 Hil-Mar Drive #402 | | |
| 10f. ZIP CODE 20747 | | | 10g. CITIZEN OF WHAT COUNTRY? United States | | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | |
| 14. RACE — American Indian, Black, White, etc. Specify: Black | | 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 12 | | | |
| 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Maintenance Tech. | | 16b. KIND OF BUSINESS/INDUSTRY Private | | | |
| 17. FATHER'S NAME (First, Middle, Last) George Hamilton H Johnson | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Mary Frances Applewhite | | |
| 19a. INFORMANT'S NAME (Type/Print) Joseph Howard Bowie | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6577 Hil-Mar Drive #402 Forestville, Md 20747 | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) HARMONY MEMORIAL PARK 7/7 | | 20c. LOCATION — City or Town, State LANDOVER, MARYLAND | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Alex S. Pope Jr.</i> M859 | | 22. NAME AND ADDRESS OF FACILITY ALEXANDER S. POPE FUNERAL HOMES 5538 Marlboro Pike, Forestville, Md 20747 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. CARDIAC ARRHYTHMIA DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): | | | | | Approximate Interval Between Onset and Death |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input checked="" type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER <i>Therese Decker</i> MN | | 29c. LICENSE NUMBER OCME | | 29d. DATE SIGNED (Month, Day, Year) JULY 01, 1995 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) MARGARET A. KOREN 111 Penn Street, Baltimore, Maryland 21201 | | | | | |
| 31. DATE FILED (Month, Day, Year) JUL 07 1995 | | 32. REGISTRAR'S SIGNATURE <i>John Anderson</i> | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 21906

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

10 0/10

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

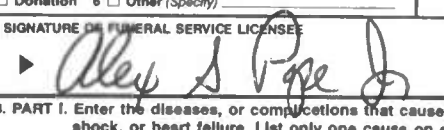
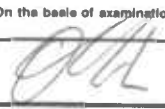
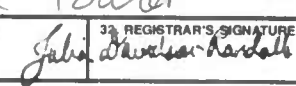
TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | | | | |
|--|--|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) WILLIS, ALBERT BUTTS | | | | 2. DATE OF DEATH MONTH DAY YEAR JULY 2, 1995 | | 3. TIME OF DEATH M 5 45 AM | |
| 4. SOCIAL SECURITY NUMBER 256-05-8234 | | 5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 79 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) FEB 2, 1916 | |
| 8. BIRTHPLACE (State or Foreign Country) GEORGIA | | | | 9a. FACILITY NAME (If not Institution, give street and number) 2103 REDWOOD TERRACE | | 9b. CITY, TOWN OR LOCATION OF DEATH TEMPLE HILLS | |
| 9c. COUNTY OF DEATH PRINCE GEORGE | | | | 10a. STATE MARYLAND | | 10b. COUNTY PRINCE GEORGE | |
| 10c. CITY, TOWN OR LOCATION TEMPLE HILLS | | | | 10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | 10e. STREET AND NUMBER 2103 REDWOOD TERRACE | |
| 10f. ZIP CODE 20748 | | | | 10g. CITIZEN OF WHAT COUNTRY? UNITED STATES | | 11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES 1942-1972 | | | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: BLACK | | 14. RACE — American Indian, Black, White, etc. Specify: BLACK | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (9-12) 12 College (1-4 or 5+) 2 | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) U.S. POSTAL SERVICE | | 16b. KIND OF BUSINESS/INDUSTRY POSTAL | |
| 17. FATHER'S NAME (First, Middle, Last) THEOPHILUS BUTTS | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) ALICE LEE BUTTS | | | |
| 19a. INFORMANT'S NAME (Type/Print) MYRTLE M. BUTTS | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2103 REDWOOD TERRACE TEMPLE HILLS MARYLAND 20748 | | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) ARLINGTON NATIONAL | | 20c. LOCATION — City or Town, State 7-13-95 ARLINGTON VA | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Alex S. Pope Jr</i> | | | | 22. NAME AND ADDRESS OF FACILITY ALEXANDER S. POPE FUNERAL HOMES 5538 MARLBORO PIKE FORESTVILLE MARYLAND | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. ADENOCARCENOMA OF THE LIVER DUE TO (OR AS A CONSEQUENCE OF): b. CARDIOPULMONARY ARREST DUE TO (OR AS A CONSEQUENCE OF): c. _____ DUE TO (OR AS A CONSEQUENCE OF): d. _____ Approximate Interval Between Onset and Death 2 MONTHS | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER <i>John L. Fay</i> | | | | 29c. LICENSE NUMBER MD-044114 | | 29d. DATE SIGNED (Month, Day, Year) JULY 5, 1995 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) DAVID L. FAY MAI USAFMC 212780628 MALCOLM GROW USAFMC | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JUL 07 1995 | | | | | | | |

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|---|--|---|--|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last) KEITH BUTLER JR | | | | 2. DATE OF DEATH MONTH JUNE DAY 28 YEAR 1995 | | 3. TIME OF DEATH 1:00 A M | |
| 4. SOCIAL SECURITY NUMBER 578-08-1715 | | 5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 15 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) JUL 10, 1979 | |
| 9a. FACILITY NAME (If not institution, give street and number) 3329 WALTERS LANE | | | | 9b. CITY, TOWN OR LOCATION OF DEATH FORESTVILLE | | 9c. COUNTY OF DEATH PRINCE GEORGE | |
| 10a. STATE Maryland | | | | 10b. COUNTY Prince Georges | | 10c. CITY, TOWN OR LOCATION Forestville | |
| 10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | | | 10e. STREET AND NUMBER 6134 Surrey Square Lane | | | |
| 10f. ZIP CODE 20747 | | | | 10g. CITIZEN OF WHAT COUNTRY? United States | | | |
| 11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: BLACK | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 10 College (1-4 or 5+) 10 | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Student | | 16b. KIND OF BUSINESS/INDUSTRY School | |
| 17. FATHER'S NAME (First, Middle, Last) Keith Jerome Butler, Sr. | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Patricia Butler (Bethea) | | | |
| 19a. INFORMANT'S NAME (Type/Print) Patricia Butler | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6134 Surrey Square Lane, Forestville, Md 20747 | | | |
| 20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input checked="" type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) | | 20c. LOCATION — City or Town, State | | 20d. DATE | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE  M859 | | | | 22. NAME AND ADDRESS OF FACILITY ALEXANDER S. POPE FUNERAL HOMES 5538 MARLBORO PIKE, FORESTVILLE, MD 20747 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Gun shot wound to head DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. | | | | | | | Approximate Interval Between Onset and Death |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | | | | | | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) 6-27-95 | | 28b. TIME OF INJURY 2308M | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED subject shot | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) Alley | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) 3329 Walters Ln. Forestville | | | |
| 29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER  | | | | 29c. LICENSE NUMBER O.C.M.E. | | 29d. DATE SIGNED (Month, Day, Year) JUNE 28, 1995 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) David R Fowler 111 Penn Street, Baltimore, Maryland 21201 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JUL 03 1995 | | | | 32. REGISTRAR'S SIGNATURE  | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 21908

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|---|--------------------------------|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last) <i>Lillian A Bobbe</i> | | | | 2. DATE OF DEATH MONTH DAY YEAR <i>June 27 1995</i> | | 3. TIME OF DEATH <i>7:12 A.M.</i> | |
| 4. SOCIAL SECURITY NUMBER <i>578-50-2013</i> | | 5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F | 6. AGE (In yrs. last birthday) <i>92</i> YRS. | IF UNDER 1 YEAR MONTHS DAYS | IF UNDER 24 HRS. HOURS MIN. | 7. DATE OF BIRTH (Month, Day, Year) <i>DEC. 2, 1902</i> | |
| 9a. FACILITY NAME (If not institution, give street and number) <i>NATIONAL LUTHERAN HOME</i> | | | | 9b. CITY, TOWN OR LOCATION OF DEATH <i>ROCKVILLE</i> | | 9c. COUNTY OF DEATH <i>MONTGOMERY</i> | |
| RESIDENCE OF DECEDENT | | | | | | | |
| 10a. STATE <i>DC</i> | | 10b. COUNTY <i>NONE</i> | | 10c. CITY, TOWN OR LOCATION <i>WASHINGTON</i> | | 10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | |
| 10e. STREET AND NUMBER <i>2519- 39th STREET, N.W.</i> | | | | 10f. ZIP CODE <i>20017</i> | | 10g. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i> | |
| 11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: <i>WHITE</i> | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <i>12</i> College (1-4 or 5+) | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <i>HAIRDRESSER</i> | | 16b. KIND OF BUSINESS/INDUSTRY <i>FED. GOVT. EMPLOYEE</i> | | | |
| 17. FATHER'S NAME (First, Middle, Last) <i>HERMAN BOBBE</i> | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) <i>ANNA PRISCO</i> | | | |
| 19a. INFORMANT'S NAME (Type/Print) <i>REV. DR. REICHARD</i> | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>9701- VEIRS DR., ROCKVILLE, MD. 20850</i> | | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <i>BICKEL MEM. CEM. 7/1</i> | | 20c. LOCATION — City or Town, State <i>AMHERST, WISCONSIN</i> | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>W. M. Hyson</i> | | | | 22. NAME AND ADDRESS OF FACILITY <i>HYSONG CO., INC. 1300- N STREET, NW., WASH., DC</i> | | | |
| 23. PART I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Coronary insufficiency</i> a. DUE TO (OR AS A CONSEQUENCE OF): <i>Arteriosclerosis</i> b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | | Approximate Interval Between Onset and Death <i>Days</i> <i>years</i> |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Acute Renal failure</i> | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO | | | | | | | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY <i>M</i> | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO | |
| | | 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i> | | | | 29c. LICENSE NUMBER <i>033138</i> | | 29d. DATE SIGNED (Month, Day, Year) <i>JUNE 27, 1995</i> | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>Daniel Jaller md 12850 Middlebrook Dr. Germantown, MD</i> | | | | | | | |
| 31. DATE FILED (Month, Day, Year) <i>JUL 03 1995</i> | | | | 32. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i> | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 21909

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) Charles H Boger | | | | 2. DATE OF DEATH MONTH DAY YEAR June 25, 1995 | | 3. TIME OF DEATH 6:30 P M | |
| 4. SOCIAL SECURITY NUMBER 237-38-6840 | | 5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 66 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) March 24, 1929 | |
| 8. BIRTHPLACE (State or Foreign Country) North Carolina | | | | 9. COUNTY OF DEATH Montgomery | | | |
| 9a. FACILITY NAME (If not institution, give street and number) Washington Adventist Hospital | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Takoma Park | | 9c. COUNTY OF DEATH Montgomery | |
| 10a. STATE Maryland | | 10b. COUNTY Prince George's | | 10c. CITY, TOWN OR LOCATION Capitol Heights | | 10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | |
| 10e. STREET AND NUMBER 6812 Walker Mill Road #101 | | | | 10f. ZIP CODE 20743 | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: Black | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12th grade | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Cook | | 16b. KIND OF BUSINESS/INDUSTRY Food | | | |
| 17. FATHER'S NAME (First, Middle, Last) Ralph Boger | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Esther Bost | | | |
| 19a. INFORMANT'S NAME (Type/Print) Mrs. Sallie Boger (Wife) | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6912 Walker Mill Road #101 Capitol Heights, Maryland 20743 | | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Glenwood Cemetery | | DATE June 30, 1995 | | 20c. LOCATION — City or Town, State Washington, D.C. | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | | | | 22. NAME AND ADDRESS OF FACILITY Rollins Funeral Home, Inc. 4339 Hunt Place, N.E. Washington, D.C. 20019 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → Renal Failure | | | | | | | |
| DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST | | | | | | | |
| DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | | | | |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO | | | | | | | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| 29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER | | | | 29c. LICENSE NUMBER D 42518 | | 29d. DATE SIGNED (Month, Day, Year) June 26, 1995 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Gul Chablani, M.D. 11119 Rockville Pike, Rockville, MD | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JUL 03 1995 | | | | 32. REGISTRAR'S SIGNATURE | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 21910

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) James Edward Brown BROWN | | | | 2. DATE OF DEATH MONTH July DAY 1 YEAR 1995 | | 3. TIME OF DEATH 0725 M | |
| 4. SOCIAL SECURITY NUMBER 220-03-8943 | | 5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 77 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) Sept 20, 1921 | |
| 8. BIRTHPLACE (State or Foreign Country) Del. | | | | 9a. FACILITY NAME (If not institution, give street and number) PENINSULA REGIONAL MEDICAL CENTER | | 9b. CITY, TOWN OR LOCATION OF DEATH SALISBURY | |
| 9c. COUNTY OF DEATH WICOMICO | | | | 10a. STATE md. | | 10b. COUNTY Wicomico | |
| 10c. CITY, TOWN OR LOCATION Salisbury | | | | 10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 10e. STREET AND NUMBER 512 Rose street | |
| 10f. ZIP CODE 21801 | | | | 10g. CITIZEN OF WHAT COUNTRY? U. S. A. | | 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | | |
| 14. RACE — American Indian, Black, White, etc. Specify: Black | | | | 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 4th College (1-4 or 5+) City of Salisbury | | | |
| 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. DO NOT use retired.) City of Salisbury | | | | 16b. KIND OF BUSINESS/INDUSTRY City of Salisbury | | | |
| 17. FATHER'S NAME (First, Middle, Last) Shelton Brown, Sr. | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Leona Mae Dashields | | | |
| 19a. INFORMANT'S NAME (Type/Print) Lillie Mae Brown | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 512 Rose Street Salisbury md. | | | |
| 20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) DATE Green Acres Cemetery 7/5 | | | |
| 20c. LOCATION — City or Town, State Salisbury md. 21801 | | | | 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | | | |
| 22. NAME AND ADDRESS OF FACILITY LEWIS N. WATSON Funeral Home 1618 W 1st Rd. Salisbury MD 21801 | | | | 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Severe COPD/Brachitis Approximate Interval Between Onset and Death years Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Severe Rheumatoid Arthritis, GI Bleeds | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | |
| 27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | | | 28a. DATE OF INJURY (Month, Day, Year) 28b. TIME OF INJURY 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO 28d. DESCRIBE HOW INJURY OCCURRED 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | 29b. SIGNATURE AND TITLE OF CERTIFIER | | | |
| 29c. LICENSE NUMBER D26616 | | | | 29d. DATE SIGNED (Month, Day, Year) 7-1-95 | | | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Michael Crouche, 105 Piz Bluff Road, Salisbury, MD 21801. | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JUL 03 1995 | | | | 32. REGISTRAR'S SIGNATURE | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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95 21911

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|---|---|--------------------------------|--|---|
| 1. DECEDENT'S NAME (First, Middle, Last) MICHAEL JOHN BRENNER | | | | 2. DATE OF DEATH MONTH DAY YEAR JUNE 30, 1995 | | 3. TIME OF DEATH 8:30 PM | |
| 4. SOCIAL SECURITY NUMBER 104-50-6953 | | 5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | 6. AGE (In yrs. last birthday) 39 YRS. | IF UNDER 1 YEAR MONTHS DAYS | IF UNDER 24 HRS. HOURS MIN. | 7. DATE OF BIRTH (Month, Day, Year) JUNE 12, 1956 | |
| 9a. FACILITY NAME (If not institution, give street and number) 6328 FEATHER HEIGHTS DRIVE | | | | 9b. CITY, TOWN OR LOCATION OF DEATH SALISBURY | | 9c. COUNTY OF DEATH WICOMICO | |
| 10a. STATE MD. | | | | 10b. COUNTY WICOMICO | | 10c. CITY, TOWN OR LOCATION SALISBURY | |
| 10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | | | | |
| 10e. STREET AND NUMBER 6328 FEATHER HEIGHTS DRIVE | | | | 10f. ZIP CODE 21801 | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMY FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No - If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE - American Indian, Black, White, etc. Specify: WHITE | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (13-16 or 17+) 1 | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) MANAGEMENT | | 16b. KIND OF BUSINESS/INDUSTRY AERO SPACE | | | |
| 17. FATHER'S NAME (First, Middle, Last) WALTER C. BRENNER | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) MARY WOROSYLLA | | | |
| 19a. INFORMANT'S NAME (Type/Print) ANNE BRENNER | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6328 FEATHER HEIGHTS DR., SALISBURY, MD. 21801 | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) GREENFIELD CEM. 7-5-95 | | 20c. LOCATION - City or Town, State HEMPSTEAD, NEW YORK | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | | | | 22. NAME AND ADDRESS OF FACILITY HOLLOWAY FUNERAL HOME, P.A. 501 SNOW HILL RD., SALISBURY, MD. 21801 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <u>metastatic Lung Cancer</u> DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events that initiated events resulting in death) LAST | | | | | | | Approximate interval Between Onset and Death |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | | | | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. PLACE OF INJURY - At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER IGNATIUS DINARDO | | | | 29c. LICENSE NUMBER 251546 | | 29d. DATE SIGNED (Month, Day, Year) 7/1/95 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 106 m. 1st st. 54.12 103 187 md 21801 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JUL 03 1995 | | 32. REGISTRAR'S SIGNATURE | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 21912

1 - FOR
STATE
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) RUZZIE ELIZABETH BRAMBLE | | | | 2. DATE OF DEATH MONTH DAY YEAR JULY 2, 1995 | | 3. TIME OF DEATH 1:00 a. M | |
| 4. SOCIAL SECURITY NUMBER 216-18-8506 | | 5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | 6. AGE (In yrs. last birthday) 84 YRS. | 7. DATE OF BIRTH (Month, Day, Year) SEPT. 24, 1910 | | 8. BIRTHPLACE (State or Foreign Country) MARYLAND | |
| 9a. FACILITY NAME (If not institution, give street and number) 4105 MAPLE DAM ROAD | | | | 9b. CITY, TOWN OR LOCATION OF DEATH CAMBRIDGE | | 9c. COUNTY OF DEATH DORCHESTER | |
| 10a. STATE MARYLAND | | 10b. COUNTY DORCHESTER | | 10c. CITY, TOWN OR LOCATION CAMBRIDGE | | 10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| 10e. STREET AND NUMBER 4105 MAPLE DAM ROAD | | | | 10f. ZIP CODE 21613 | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: WHITE | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 6 College (13-16 or 17+) | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) HOUSEWIFE | | 16b. KIND OF BUSINESS/INDUSTRY HOMEMAKER | | | |
| 17. FATHER'S NAME (First, Middle, Last) CHARLES BENNETT ROBBINS | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) ALVERTA SHORTER | | | |
| 19a. INFORMANT'S NAME (Type/Print) FAYE BROHAWN | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 426 LEONARDS LANE, CAMBRIDGE, MD. 21613 | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) SANDY ISLAND CEMETERY 7-5 | | 20c. LOCATION — City or Town, State CAMBRIDGE, MD. | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Faye Brohawn</i> | | | | 22. NAME AND ADDRESS OF FACILITY CURRAN-BROMWELL FUNERAL HOME, P.A. 308 HIGH ST., CAMBRIDGE, MD. 21613 | | | |
| 23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. <i>Hypoxemia</i> DUE TO (OR AS A CONSEQUENCE OF): b. <i>Pleural Effusion</i> DUE TO (OR AS A CONSEQUENCE OF): c. <i>Breast Cancer</i> DUE TO (OR AS A CONSEQUENCE OF): d. Approximate Interval Between Onset and Death <i>2 weeks</i> <i>2 month</i> <i>4 years</i> | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Congestive Heart Failure</i> | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| | | 28d. DESCRIBE HOW INJURY OCCURRED | | | | 28e. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER <i>Rosemary M. Harris MD</i> | | | | 29c. LICENSE NUMBER <i>D-43707</i> | | 29d. DATE SIGNED (Month, Day, Year) <i>July 5, 1995</i> | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) ROSEMARY M. HARRIS, M.D., 408 BYRN ST., CAMBRIDGE, MD. 21613 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JUL 06 1995 | | | | 32. REGISTRAR'S SIGNATURE <i>John Davidson-Rodall</i> | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 687600 BALTIMORE, MARYLAND 21215-0020

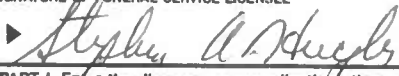
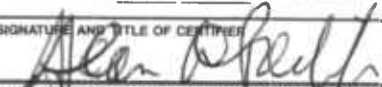
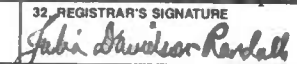
TO THE HOSPITAL DR. ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 21913

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|--|--|---|--|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last) Tyler Michael BYNION | | | | 2. DATE OF DEATH MONTH DAY YEAR July 03 1995 | | 3. TIME OF DEATH 10:30 A M | |
| 4. SOCIAL SECURITY NUMBER none | | 5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) YRS. MONTHS DAYS 0 4 | | 7. DATE OF BIRTH (Month, Day, Year) June 29, 1995 | |
| 8a. FACILITY NAME (If not institution, give street and number) Franklin Square Hospital | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Rossville | | 9c. COUNTY OF DEATH Baltimore | |
| 10a. STATE Maryland | | 10b. COUNTY Harford | | 10c. CITY, TOWN OR LOCATION Bel Air | | 10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | |
| 10e. STREET AND NUMBER 9 Shamrock Road | | | | 10f. ZIP CODE 21014 | | 10g. CITIZEN OF WHAT COUNTRY? USA | |
| 11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: white | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) n/a College (1-4 or 5+) n/a | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) n/a | | 16b. KIND OF BUSINESS/INDUSTRY n/a | | | |
| 17. FATHER'S NAME (First, Middle, Last) Ronald Brian Bynion | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Donna Marie Kalkowski | | | |
| 19a. INFORMANT'S NAME (Type/Print) Ronald Brian Bynion | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9 Shamrock Road, Bel Air, Maryland 21014 | | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Bel Air Memorial Gardens 7/6/95 | | 20c. LOCATION — City or Town, State Bel Air, Maryland | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE  | | | | 22. NAME AND ADDRESS OF FACILITY Howard K. McComas III Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Md. 21009 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Severe hyaline membrane disease DUE TO (OR AS A CONSEQUENCE OF): b. Severe neonatal pneumonia DUE TO (OR AS A CONSEQUENCE OF): c. Prematurity DUE TO (OR AS A CONSEQUENCE OF): d. Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | | Approximate Interval Between Onset and Death 4 days 4 days 4 days |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| | | 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER  CHIEF, SECTION OF NEUROLOGY | | | | 29c. LICENSE NUMBER D42595 | | 29d. DATE SIGNED (Month, Day, Year) 7/5/95 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Dr. Alan Bedrick 9000 Franklin Square Drive Baltimore Md. 21237-3998 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JUL 06 1995 | | 32. REGISTRAR'S SIGNATURE  | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68769

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician.

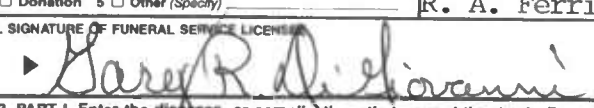
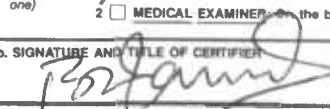
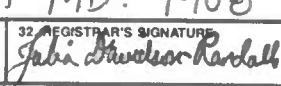
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 21914

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|--|--|--|--|--|---|
| 1. DECEDENT'S NAME (First, Middle, Last) Ruth Ellen Burnette | | | | 2. DATE OF DEATH MONTH DAY YEAR July 6, 1995 | | 3. TIME OF DEATH 3:00 p.m. | |
| 4. SOCIAL SECURITY NUMBER 215-34-6156 | | 5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 57 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) Sept. 5, 1937 | |
| 9a. FACILITY NAME (If not institution, give street and number) 826 Lynn Lee Drive | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Aberdeen | | 9c. COUNTY OF DEATH Harford | |
| RESIDENCE OF DECEDENT | | | | | | | |
| 10a. STATE Maryland | | 10b. COUNTY Harford | | 10c. CITY, TOWN OR LOCATION Aberdeen | | 10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| 10e. STREET AND NUMBER 826 Lynn Lee Drive | | | | 10f. ZIP CODE 21001 | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 10 College (1-4 or 5+) 0 | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Homemaker | | 16b. KIND OF BUSINESS/INDUSTRY In home | | | |
| 17. FATHER'S NAME (First, Middle, Last) Harold Vance Travers | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Sara Elizabeth Armour | | | |
| 19a. INFORMANT'S NAME (Type/Print) Mr. Michael R. Travers | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 528 Bonnie Drive Aberdeen, Maryland 21001 | | | |
| 20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) R. A. Ferris & Co., Inc. 7/7 | | 20c. LOCATION — City or Town, State West Chester, PA | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE  | | | | 22. NAME AND ADDRESS OF FACILITY Tarring-Cargo Funeral Home, P.A. Aberdeen, MD 21001-3399 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | | a. Metastatic Bone Cancer Primary Unknown | | | | | Approximate interval Between Onset and Death 6 months |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | b. Respiratory Acidosis Hypercarbia. | | | | | 1 yr. |
| | | c. Emphysema. | | | | | 10 yrs |
| | | d. | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28d. DESCRIBE HOW INJURY OCCURRED | | | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER  | | 29c. LICENSE NUMBER B.D. PAREKH MD D18424 | | 29d. DATE SIGNED (Month, Day, Year) July-7-1995 | | | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) B.D. PAREKH MD. 1908 HARFORD ROAD FALLSTON MD 21047 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JUL 07 1995 | | | | 32. REGISTRAR'S SIGNATURE  | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 21915

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|---|--|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last) VENUS P. BRAND | | | | 2. DATE OF DEATH MONTH DAY YEAR July 6, 1995 | | 3. TIME OF DEATH 3:30 P M | |
| 4. SOCIAL SECURITY NUMBER 298-20-9498 | | 5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 89 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) Oct. 16, 1905 Ohio | |
| 9a. FACILITY NAME (If not institution, give street and number) 4025 Tabernacle Road | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Whiteford | | 9c. COUNTY OF DEATH Harford | |
| 10a. STATE MD | | 10b. COUNTY Harford | | 10c. CITY, TOWN OR LOCATION Whiteford | | 10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| 10e. STREET AND NUMBER 4025 Tabernacle Road | | | | 10f. ZIP CODE 21160 | | 10g. CITIZEN OF WHAT COUNTRY? USA | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Unknown | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Homemaker | | 16b. KIND OF BUSINESS/INDUSTRY | | | |
| 17. FATHER'S NAME (First, Middle, Last) Ira Keith | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Elizabeth Emery | | | |
| 19a. INFORMANT'S NAME (Type/Print) Edith L. Kesterson | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4025 Tabernacle Rd. Whiteford, MD., 21160 | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Union Cemetery | | 20c. LOCATION — City or Town, State Columbus, Ohio | | 20d. DATE | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>John H. Tillet</i> | | | | 22. NAME AND ADDRESS OF FACILITY Harkins F.H. Inc., Delta, PA., 17314 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Carcinoma of Liver, Metastatic Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. _____ c. _____ d. _____ | | | | | | | Approximate Interval Between Onset and Death 1 month |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Coronary Artery Disease Congestive Heart Failure | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | | | | DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA | | 28. PLACE OF DEATH (Check only one) OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | 28g. DATE SIGNED (Month, Day, Year) July 7, 1995 | | | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER <i>Leticia S. Galvez</i> | | | | 29c. LICENSE NUMBER D 15994 | | 29d. DATE SIGNED (Month, Day, Year) July 7, 1995 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Leticia S. Galvez, M.D., 625 S. Union, Havre de Grace, MD. | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JUL 07 1995 | | | | 32. REGISTRAR'S SIGNATURE <i>John A. Randall</i> | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 21916

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) JOHN ELDRIDGE BURROUGHS | | | | 2. DATE OF DEATH MONTH JULY 3 DAY 1995 YEAR 1995 | | 3. TIME OF DEATH 11:30 A M | |
| 4. SOCIAL SECURITY NUMBER 220-26-4873 | | 5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 67 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) February 4 1928 | |
| 8. BIRTHPLACE (State or Foreign Country) MARYLAND | | | | 9a. FACILITY NAME (If not institution, give street and number) 12540 SWAN POINT ROAD | | 9b. CITY, TOWN OR LOCATION OF DEATH ISSUE | |
| 9c. COUNTY OF DEATH CHARLES | | | | 10a. STATE MARYLAND | | 10b. COUNTY CHARLES | |
| 10c. CITY, TOWN OR LOCATION ISSUE | | | | 10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 10e. STREET AND NUMBER 12540 SWAN POINT ROAD | |
| 10f. ZIP CODE 20664 | | | | 10g. CITIZEN OF WHAT COUNTRY? | | 11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: BLACK | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 7 College (1-4 or 5+) 7 | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) CARPENTER | | 16b. KIND OF BUSINESS/INDUSTRY SELF EMPLOYED | |
| 17. FATHER'S NAME (First, Middle, Last) IGNATIUS C. BURROUGHS | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) MARY VIRGIE (JOHNSON) BURROUGH | | | |
| 19a. INFORMANT'S NAME (Type/Print) LUVENIA THOMPSON | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 622 19th St. N.E. Apt #1 WASHINGTON, D.C. 20002 | | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) HOLY GHOST CHURCH CEMETERY 7/8/95 | | 20c. LOCATION — City or Town, State ISSUE, MARYLAND | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Leon Thornton</i> LEON THORNTON | | | | 22. NAME AND ADDRESS OF FACILITY THORNTON FUNERAL HOME 3435 LIVINGSTON ROAD POMNKEY, MD. 20640 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → Atherosclerotic Cardiovascular disease | | | | | | | |
| Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST | | | | | | | |
| a. DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| b. DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| c. DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| d. DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | | | | |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | | | | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | |
| 27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | |
| 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | 28d. DESCRIBE HOW INJURY OCCURRED | | | |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER <i>Deputy M.E. Ch. City</i> | | | | 29c. LICENSE NUMBER D46419 | | 29d. DATE SIGNED (Month, Day, Year) 7/3/95 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JUL 07 1995 | | | | 32. REGISTRAR'S SIGNATURE <i>John Davidson-Randall</i> | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 21917

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|---|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) Baby Boy BROWN | | | | 2. DATE OF DEATH MONTH 6 DAY 16 YEAR 95 | | 3. TIME OF DEATH 03⁴⁰ - A^M | |
| 4. SOCIAL SECURITY NUMBER none | | 5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 0 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 6/15/95 | |
| 9a. FACILITY NAME (If not institution, give street and number) Johns Hopkins Bayview Medical Center | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Baltimore | | 9c. COUNTY OF DEATH Baltimore | |
| 10a. STATE MD | | | | 10b. COUNTY Baltimore | | 10c. CITY, TOWN OR LOCATION Baltimore | |
| 10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | | | 10e. STREET AND NUMBER 4940 Eastern Ave Baltimore MD | | | |
| 10f. ZIP CODE 21224 | | | | 10g. CITIZEN OF WHAT COUNTRY? USA | | | |
| 11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: black | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 0 College (1-4 or 5+) 0 | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) none | | 16b. KIND OF BUSINESS/INDUSTRY none | | | |
| 17. FATHER'S NAME (First, Middle, Last) unknown | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Mary | | | |
| 19a. INFORMANT'S NAME (Type/Print) Mary Brown | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 515 N. Belnord Ave Baltimore MD 21205 | | | |
| 20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input checked="" type="checkbox"/> Donation <input checked="" type="checkbox"/> Other (Specify) hospital disposal | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Baltimore, MD | | 20c. LOCATION — City or Town, State Baltimore, MD | | 20d. DATE 6/16/95 | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Johns Hopkins Bayview Medical Center | | | | 22. NAME AND ADDRESS OF FACILITY 4940 Eastern Ave Baltimore, MD 21224 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | | a. PULMONARY FAILURE DUE TO (OR AS A CONSEQUENCE OF): | | | | Approximate Interval Between Onset and Death 14 h | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | b. RESPIRATORY DISTRESS SYNDROME DUE TO (OR AS A CONSEQUENCE OF): | | | | 14 h 17^m | |
| | | c. PREMATURITY - EXTREME DUE TO (OR AS A CONSEQUENCE OF): | | | | 14 h 17^m | |
| | | d. PULMONARY HYPERTENSION DUE TO (OR AS A CONSEQUENCE OF): | | | | 8 h | |
| | | PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. PULMONARY HEMORRHAGE PNEUMOTHORAX | | | | 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 25. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide 3 <input type="checkbox"/> Homicide 7 <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER G. Alpan MD | | | | 29c. LICENSE NUMBER D42096 | | 29d. DATE SIGNED (Month, Day, Year) 6/16/95 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) G. ALPAN, 4940 EASTERN AVE, BALTIMORE, MD 21224 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JUL 20 1995 | | | | 32. REGISTRAR'S SIGNATURE John A. Anderson-Randall | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95-4003-045

B.K.S

Item 23 Part I, 27 8-1-95 Film G726 W.H. Per OCME

95 21918

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | | | | | | |
|---|--|--|---|---|--------------------------------|--|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) LARRY D. BELL | | | | 2. DATE OF DEATH JULY 10, 1995 | | | | 3. TIME OF DEATH 2312 P M | |
| 4. SOCIAL SECURITY NUMBER 216-74-7975 | | 5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | 6. AGE (In yrs. last birthday) 35 YRS. | IF UNDER 1 YEAR MONTHS DAYS | IF UNDER 24 HRS. HOURS MIN. | 7. DATE OF BIRTH (Month, Day, Year) 3/21/1960 | | 8. BIRTHPLACE (State or Foreign Country) Md. | |
| 9a. FACILITY NAME (If not institution, give street and number) PENINSULA REGIONAL HOSPITAL | | | | 9b. CITY, TOWN OR LOCATION OF DEATH SALISBURY | | | 9c. COUNTY OF DEATH WICOMICO | | |
| RESIDENCE OF DECEDENT | | | | | | | | | |
| 10a. STATE Md | | 10b. COUNTY Wicomico | | 10c. CITY, TOWN OR LOCATION Nanticoke | | | | 10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 10e. STREET AND NUMBER P.O. BOX 30, NUTTER ROAD | | | | 10f. ZIP CODE 21840 | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | | | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | | 14. RACE — American Indian, Black, White, etc. Specify: Black | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 11 | | College (1-4 or 8+) | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Laborer | | | 16b. KIND OF BUSINESS/INDUSTRY ----- | | |
| 17. FATHER'S NAME (First, Middle, Last) Donald Bell | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Hilda Showell | | | | | |
| 19a. INFORMANT'S NAME (Type/Print) Hilda Showell | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) P.O. Box 30, Nanticoke, Md. 21840 | | | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory, or other place) Tyaskin Cem. 7/16 | | DATE | | 20c. LOCATION — City or Town, State Tyaskin, Md. | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Concha Simpson</i> MOO-417 | | | | 22. NAME AND ADDRESS OF FACILITY MESSICK FUNERAL HOME, P.O. Box 61 BIVOLVE, MD. 21814 | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Arteriosclerotic Cardiovascular Disease DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST | | | | | | | | Approximate Interval Between Onset and Death | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED | |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | |
| 29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER <i>John Locke MD</i> | | | | 29c. LICENSE NUMBER O.C.M.E | | 29d. DATE SIGNED (Month, Day, Year) JULY 11, 1995 | | | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>John Locke MD</i> 11 Penn Street, Baltimore, Maryland 21201 | | | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JUL 20 1995 | | | | 32. REGISTRAR'S SIGNATURE <i>John Andrew Randall</i> | | | | | |

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 21919

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|--|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) Catherine Augusta Cissell | | | | 2. DATE OF DEATH MONTH DAY YEAR July 2, 1995 | | 3. TIME OF DEATH 9:15 A M | |
| 4. SOCIAL SECURITY NUMBER 218-26-6677 | | 5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 104 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) April 29, 1891 | |
| 8. BIRTHPLACE (State or Foreign Country) New Jersey | | | | 9a. FACILITY NAME (If not institution, give street and number) Greenbelt Nursing Center | | 9b. CITY, TOWN OR LOCATION OF DEATH Greenbelt | |
| 9c. COUNTY OF DEATH Prince George's | | | | 10a. STATE Maryland | | 10b. COUNTY Prince George's | |
| 10c. CITY, TOWN OR LOCATION Greenbelt | | | | 10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 10e. STREET AND NUMBER 6411 Ivy Lane, Suite 200 | |
| 10f. ZIP CODE 20770 | | | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | | 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) unavailable College (1-4 or 5+) unavailable | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) unavailable | | 16b. KIND OF BUSINESS/INDUSTRY unavailable | |
| 17. FATHER'S NAME (First, Middle, Last) (first name unavailable) Myers | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) unavailable | | | |
| 19a. INFORMANT'S NAME (Type/Print) David A. McNamee | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6411 Ivy Lane, Suite 200, Greenbelt, MD 20770 | | | |
| 20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Metropolitan Crematory 7/04/95 | | 20c. LOCATION — City or Town, State Alexandria, Virginia | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Charles F. Bell | | | | 22. NAME AND ADDRESS OF FACILITY Francis Gasch's Sons Funeral Home, P.A. 4739 Baltimore Ave., Hyattsville, MD 20781 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Cardiopulmonary arrest | | | | | | | |
| b. Probable Sepsis | | | | | | | |
| Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST c. DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| d. DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Severe atherosclerosis with marked peripheral vascular disease | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide 3 <input type="checkbox"/> Homicide 8 <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER St. Thomas | | | | 29c. LICENSE NUMBER D379341 | | 29d. DATE SIGNED (Month, Day, Year) 7/3/95 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) S. TRIFOLLO, MD 7500 Greenway Ctr Drive Greenbelt MD 20770 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JUL 06 1995 | | | | 32. REGISTRAR'S SIGNATURE John A. ... | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 21920

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | |
|---|--|---|--|---|--|--|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) <u>Hilton</u> | | | | 2. DATE OF DEATH MONTH <u>July</u> DAY <u>1</u> YEAR <u>95</u> | | | | 3. TIME OF DEATH <u>11:14 P M</u> | |
| 4. SOCIAL SECURITY NUMBER <u>579-30-9612</u> | | 5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) <u>68</u> YRS. | | IF UNDER 1 YEAR MONTHS <u> </u> DAYS <u> </u> | | IF UNDER 24 HRS. HOURS <u> </u> MIN. <u> </u> | |
| 7. DATE OF BIRTH (Month, Day, Year) <u>Feb. 14, 1927</u> | | | | 8. BIRTHPLACE (State or Foreign Country) <u>Virginia</u> | | | | | |
| 9a. FACILITY NAME (If not institution, give street and number) <u>Holy Cross Hospital</u> | | | | 9b. CITY, TOWN OR LOCATION OF DEATH <u>Silver Spring</u> | | | | 9c. COUNTY OF DEATH <u>Montgomery</u> | |
| RESIDENCE OF DECEDENT | | | | | | | | | |
| 10a. STATE <u>Maryland</u> | | 10b. COUNTY <u>Montgomery</u> | | 10c. CITY, TOWN OR LOCATION <u>Rockville</u> | | | | 10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | |
| 10e. STREET AND NUMBER <u>12600 Viers Mill Road</u> | | | | 10f. ZIP CODE <u>20906</u> | | 10g. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | | | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | | | 14. RACE — American Indian, Black, White, etc. Specify: <u>White</u> | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <u>6</u> College (1-4 or 5+) <u> </u> | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <u>Bakery Foreman</u> | | | | 16b. KIND OF BUSINESS/INDUSTRY <u>Bakery Industry</u> | |
| 17. FATHER'S NAME (First, Middle, Last) <u>William James Campbell</u> | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) <u>Fannie Kube</u> | | | | | |
| 19a. INFORMANT'S NAME (Type/Print) <u>Mary G. Campbell</u> | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>12600 Viers Mill Road, Rockville, Maryland 20906</u> | | | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <u>Parklawn Cemetery</u> | | DATE <u>07/06/95</u> | | 20c. LOCATION — City or Town, State <u>Rockville, Maryland</u> | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <u>Charles F. Bell</u> | | | | 22. NAME AND ADDRESS OF FACILITY <u>Francis Gasch's Sons Funeral Home, P.A.</u> <u>4739 Baltimore Ave., Hyattsville, MD 20781</u> | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <u>a. arteriosclerotic Heart Disease</u> DUE TO (OR AS A CONSEQUENCE OF): b. <u> </u> DUE TO (OR AS A CONSEQUENCE OF): c. <u> </u> DUE TO (OR AS A CONSEQUENCE OF): d. <u> </u> Approximate Interval Between Onset and Death <u>years</u> | | | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>diabetes mellitus</u> | | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | | | | | | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY <u>M</u> | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 28d. DESCRIBE NOW INJURY OCCURRED | |
| | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER <u>John Tauber MD</u> | | | | | | 29c. LICENSE NUMBER <u>D08546</u> | | 29d. DATE SIGNED (Month, Day, Year) <u>July 2-95</u> | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <u>John Tauber</u> <u>8218 Wisconsin Ave Bethesda</u> | | | | | | | | | |
| 31. DATE FILED (Month, Day, Year) <u>JUL 06 1995</u> | | | | 32. REGISTRAR'S SIGNATURE <u>John Tauber</u> | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 21921

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) CORA CRIDER | | | | 2. DATE OF DEATH MONTH DAY YEAR JUNE 26, 1995 | | 3. TIME OF DEATH 7:10 P.M. | |
| 4. SOCIAL SECURITY NUMBER 086-07-9929 | | 5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 92 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) JANUARY 29, 03 | |
| 9a. FACILITY NAME (If not institution, give street and number) ARCOLA NURSING HOME | | | | 9b. CITY, TOWN OR LOCATION OF DEATH WHEATON | | 9c. COUNTY OF DEATH MONTGOMERY | |
| RESIDENCE OF DECEDENT | | | | | | | |
| 10a. STATE MARYLAND | | 10b. COUNTY MONTGOMERY | | 10c. CITY, TOWN OR LOCATION SILVER SPRING | | 10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 10e. STREET AND NUMBER 901 ARCOLA DRIVE | | | | 10f. ZIP CODE 20902 | | 10g. CITIZEN OF WHAT COUNTRY? UNITED STATES AMER. | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: BLACK | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 9th College (1-4 or 5+) NURSE | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) PRIVATE | | 16b. KIND OF BUSINESS/INDUSTRY PRIVATE | | | |
| 17. FATHER'S NAME (First, Middle, Last) JAMES R. ALSOBROOKS | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) MIMMIE STURIVANT | | | |
| 19a. INFORMANT'S NAME (Type/Print) LORETTA NORRIS (SISTER) | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 649 KENSINGTON PLACE, N.E.; WASHINGTON, D.C. 20011 | | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input checked="" type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) KENSICO CEMETERY 6/30/95 | | 20c. LOCATION — City or Town, State, Zip Code VALHALLA, NEW YORK 10595 | | | |
| 21. SIGNATURE OF FUNERAL HOME REPRESENTATIVE CHANDA M. FREEMAN | | | | 22. NAME AND ADDRESS OF FACILITY JOHNSON & JENKINS FUNERAL HOME, INC. 716 KENNEDY STREET, N.W.; WDC 20011 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | | | | | | | |
| a. SEPTICEMIA | | | | | | | |
| b. GANGRENE LEG | | | | | | | |
| c. PERIPHERAL VASCULAR INSUFFICIENCY | | | | | | | |
| d. PERIPHERAL VASCULAR INSUFFICIENCY | | | | | | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | | | | |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28d. DESCRIBE HOW INJURY OCCURRED | | | | | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER Martin C. Shargel M.D. | | | | 29c. LICENSE NUMBER D08944 | | 29d. DATE SIGNED (Month, Day, Year) JUNE 27, 1995 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) MARTIN C. SHARGEL, M.D. | | | | 31. DATE FILED (Month, Day, Year) JUN 28 1995 | | | |
| 32. REGISTRAR'S SIGNATURE John D. ... | | | | 33. DATE OF DEATH (Month, Day, Year) JUNE 26, 1995 | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 21922

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) Ethel M. Crandall | | | | 2. DATE OF DEATH MONTH DAY YEAR June 23 1995 | | 3. TIME OF DEATH 6:00 A M | |
| 4. SOCIAL SECURITY NUMBER 495-16-1030 | | 5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 96 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) April 27, 1899 | |
| 8. BIRTHPLACE (State or Foreign Country) Connecticut | | | | 9a. FACILITY NAME (If not institution, give street and number) 12602 Brunswick Lane | | 9b. CITY, TOWN OR LOCATION OF DEATH Bowie | |
| 9c. COUNTY OF DEATH Prince Georges | | | | 10a. STATE Maryland | | 10b. COUNTY Prince Georges | |
| 10c. CITY, TOWN OR LOCATION Bowie | | | | 10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 10e. STREET AND NUMBER 12602 Brunswick Lane | |
| 10f. ZIP CODE 20715 | | | | 10g. CITIZEN OF WHAT COUNTRY? USA | | | |
| 11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) College | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Stenographer | | 16b. KIND OF BUSINESS/INDUSTRY Merkle Press | | | |
| 17. FATHER'S NAME (First, Middle, Last) Sherwood Burr Gorham | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Estella Warner | | | |
| 19a. INFORMANT'S NAME (Type/Print) Gordon Crandall | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1524 Birdwood Court Crofton, Md. 21114 | | | |
| 20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Metropolitan Crematory 6-24-95 | | 20c. LOCATION — City or Town, State Alexandria, Virginia | | 20d. DATE 6-24-95 | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Robert E. Evans, Pres. | | | | 22. NAME AND ADDRESS OF FACILITY Robert E. Evans Funeral Home, P.A. 16000 Annapolis Road Bowie, Md. 20715 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Cardiac arrhythmia. Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): Congestive heart failure. c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/> | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER Routan Farahi M.D. | | | | 29c. LICENSE NUMBER D43446 | | 29d. DATE SIGNED (Month, Day, Year) 6/24/95 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) ROINTAN FARABI-FAR M.D. 4000 Mitchellville road #B216 Bowie MD 20716 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JUN 28 1995 | | | | 32. REGISTRAR'S SIGNATURE John Davidson Randall | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 21923

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|---|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) Florence Kathryn Cambre | | | | 2. DATE OF DEATH MONTH DAY YEAR July 2, 1995 | | 3. TIME OF DEATH 2145 Hrs. M | |
| 4. SOCIAL SECURITY NUMBER 579-32-3920 | | 5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 73 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) July 4, 1921 | |
| 8. FACILITY NAME (If not institution, give street and number) Southern Maryland Hospital | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Clinton | | 9c. COUNTY OF DEATH Prince George's | |
| RESIDENCE OF DECEDENT | | | | | | | |
| 10a. STATE Maryland | | 10b. COUNTY Prince George's | | 10c. CITY, TOWN OR LOCATION Temple Hills | | 10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| 10e. STREET AND NUMBER 7114 Buchanan Road | | | | 10f. ZIP CODE 20748 | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: Caucasian | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12th | | 15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Clerk Secretary/Cryptographic | | 16b. KIND OF BUSINESS/INDUSTRY U.S. Government | | | |
| 17. FATHER'S NAME (First, Middle, Last) Gilbert DiNicola | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Anna Febo | | | |
| 19a. INFORMANT'S NAME (Type/Print) Anna Cook | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8705 Mount Clair Ct. Clinton, Maryland 20735 | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Arlington National Cem. 1995 | | 20c. LOCATION — City or Town, State Arlington Virginia | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | | | | 22. NAME AND ADDRESS OF FACILITY Lee Funeral Home, Inc. 6633 Old Alexandria Ferry Rd Clinton, Md | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | | Carcinoma of the breast and urinary bladder | | | | | |
| | | DUE TO (OR AS A CONSEQUENCE OF): | | | | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | DUE TO (OR AS A CONSEQUENCE OF): | | | | | |
| | | DUE TO (OR AS A CONSEQUENCE OF): | | | | | |
| | | DUE TO (OR AS A CONSEQUENCE OF): | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER | | | | 29c. LICENSE NUMBER A21230 | | 29d. DATE SIGNED (Month, Day, Year) July 3/1995 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Augusto P. Rodriguez M.D. | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JUL 06 1995 | | | | 32. REGISTRAR'S SIGNATURE | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 21924

1 - FOR
STATE
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

| | | | | | | | | | | | |
|---|--|---|--|---|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) Patrick James Coyle | | | | 2. DATE OF DEATH MONTH DAY YEAR June 30, 1995 | | 3. TIME OF DEATH 3:53 M | | | | | |
| 4. SOCIAL SECURITY NUMBER 036-38-1488 | | 5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 38 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) July 28, 1956 | | 8. BIRTHPLACE (State or Foreign Country) New York | | | |
| 9a. FACILITY NAME (If not institution, give street and number) 1916 Rochelle Avenue Apt 1312 | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Forestville | | | 9c. COUNTY OF DEATH Prince George's | | | | |
| 10a. STATE Maryland | | | 10b. COUNTY Prince George's | | 10c. CITY, TOWN OR LOCATION Forestville | | | 10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | |
| 10e. STREET AND NUMBER 1916 Rochelle Avenue Apt. 1312 | | | | 10f. ZIP CODE 20747 | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | | | | | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES 1977-1994 | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: Caucasian | | | | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 2 | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Supply Air Force Presidential | | | 16b. KIND OF BUSINESS/INDUSTRY United States Air Force | | | | | |
| 17. FATHER'S NAME (First, Middle, Last) John A. Coyle | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Mary M. Ryan | | | | | | | |
| 19a. INFORMANT'S NAME (Type/Print) Ann Carter | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3104 Rock Hill Lane Belleville IL. 62221 | | | | | | | |
| 20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Lee Crematory July 5, 1995 | | 20c. LOCATION — City or Town, State Clinton, Maryland | | | | | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | | | | 22. NAME AND ADDRESS OF FACILITY Lee Funeral Home, Inc. 6633 Old Alexandria Ferry Rd Clinton, Md 20735 | | | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Acquired Immune Deficiency Syndrome DUE TO (OR AS A CONSEQUENCE OF): Sequitentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. | | | | | | | | Approximate Interval Between Onset and Death | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 6 <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED | | | |
| | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER | | | | | | 29c. LICENSE NUMBER MD-D36213 | | 29d. DATE SIGNED (Month, Day, Year) 30 June 95 | | | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) MALCOLM GROW Medical Center, Andrews AFB, MD 20331 | | | | | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JUL 06 1995 | | | | 32. REGISTRAR'S SIGNATURE | | | | | | | |


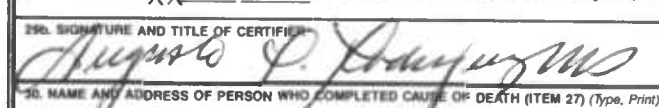
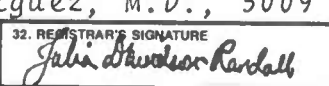
DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 21925

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|---|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) PHILIP EDMUND CARUFEL | | | | 2. DATE OF DEATH MONTH JULY DAY 4 YEAR 1995 | | 3. TIME OF DEATH 12:50 P M | |
| 4. SOCIAL SECURITY NUMBER 258-48-9665 | | 5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 8. AGE (In yrs. last birthday) 60 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) June 29, 1935 | |
| 9a. FACILITY NAME (If not institution, give street and number) Prince George's Hospital Center | | 9b. CITY, TOWN OR LOCATION OF DEATH Cheverly | | 9c. COUNTY OF DEATH Prince George's | | | |
| 10a. STATE Maryland | | 10b. COUNTY Prince George's | | 10c. CITY, TOWN OR LOCATION Hyattsville | | 10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 10e. STREET AND NUMBER 5603 Quincy Street | | | | 10f. ZIP CODE 20784 | | 10g. CITIZEN OF WHAT COUNTRY? United States | |
| 11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES 1953-1962 | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (14 or 5+) _____ | | 15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Carpenter | | 15b. KIND OF BUSINESS/INDUSTRY Self-Employed | | | |
| 17. FATHER'S NAME (First, Middle, Last) Samuel S. Carufel | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Eva F. Supernant | | | |
| 19a. INFORMANT'S NAME (Type/Print) Linda K. Singh | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6539 Quail Hollow Dr., Manassas, Va 22111 | | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Maryland Veterans Cem. July 7, 1995 | | 20c. LOCATION — City or Town, State Cheltenham, Maryland | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE  | | | | 22. NAME AND ADDRESS OF FACILITY Lee Funeral Home, Inc 6633 Old Alexander Ferry Rd, Clinton, M | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Pneumonia With Sepsis DUE TO (OR AS A CONSEQUENCE OF): b. Small Cell Cancer, Lung DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| 29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER  | | | | 29c. LICENSE NUMBER A21230 | | 29d. DATE SIGNED (Month, Day, Year) July 5, 1995 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Augusto P. Rodriguez, M.D., 5009 Rayburn Court Camp Springs, Md. 20748 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JUL 06 1995 | | | | 32. REGISTRAR'S SIGNATURE  | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 21926

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) Frank Clements | | | | 2. DATE OF DEATH MONTH DAY YEAR June 25, 1995 | | 3. TIME OF DEATH 10:00 PM | |
| 4. SOCIAL SECURITY NUMBER 579-10-5560 | | 5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 74 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) Dec 13, 1920 | |
| 8. BIRTHPLACE (State or Foreign Country) Washington | | | | 9a. FACILITY NAME (If not Institution, give street and number) Bowie Health Care Center | | 9b. CITY, TOWN OR LOCATION OF DEATH Bowie | |
| 9c. COUNTY OF DEATH Prince George's | | | | 10a. STATE Maryland | | 10b. COUNTY Kennsington | |
| 10c. STREET AND NUMBER 11304 Lund Place | | | | 10d. ZIP CODE 20895 | | 10e. CITIZEN OF WHAT COUNTRY? United States | |
| 11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES 1942-1945 | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 2 | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) President | | 16b. KIND OF BUSINESS/INDUSTRY Fries, Beall and Sharp | |
| 17. FATHER'S NAME (First, Middle, Last) Vete Clements | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Edna Pearl Meinburg | | | |
| 19a. INFORMANT'S NAME (Type/Print) Marie Lomax | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 109 Riverside Road, Edgewater, Md 21037 | | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Sedar Hill Cemetery June 28, 1995 | | 20c. LOCATION — City or Town, State Suitland, Md | | 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | |
| 22. NAME AND ADDRESS OF FACILITY Lee Funeral Home, Inc 6633 Old Alexander Ferry Rd, Clinton | | | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Respiratory Failure DUE TO (OR AS A CONSEQUENCE OF): Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST { b. End Stage Cardiomyopathy; CHF. DUE TO (OR AS A CONSEQUENCE OF): c. Renal Failure DUE TO (OR AS A CONSEQUENCE OF): d. Dysphagia; CVA (multiple) | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/> | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO N/A | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | | | 28e. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER | | | | 29c. LICENSE NUMBER D-34525 | | 29d. DATE SIGNED (Month, Day, Year) 6-26-95 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) S-J. Bao, MD - 4000 Mitchellville Rd #220; Bowie-MD-20716 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JUL 06 1995 | | | | 32. REGISTRAR'S SIGNATURE | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 21927

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) TANYA SUE CHECHE | | | | 2. DATE OF DEATH MONTH DAY YEAR July 4, 1995 | | 3. TIME OF DEATH 1:30 A M | |
| 4. SOCIAL SECURITY NUMBER 480-54-2449 | | 5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 46 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) Sept. 14, 1948 | |
| 8. BIRTHPLACE (State or Foreign Country) Iowa | | | | 9a. FACILITY NAME (If not institution, give street and number) 20 Middlegrove Court W | | 9b. CITY, TOWN OR LOCATION OF DEATH Westminster | |
| 9c. COUNTY OF DEATH Carroll | | | | 10a. STATE Maryland | | 10b. COUNTY Carroll | |
| 10c. CITY, TOWN OR LOCATION Westminster | | | | 10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 10e. STREET AND NUMBER 20 Middlegrove Court W | |
| 10f. ZIP CODE 21157 | | | | 10g. CITIZEN OF WHAT COUNTRY? United States | | 11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced | |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | | |
| 14. RACE — American Indian, Black, White, etc. Specify: White | | | | 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) College | | | |
| 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Regulatory Analyst | | | | 16b. KIND OF BUSINESS/INDUSTRY Spice Company | | | |
| 17. FATHER'S NAME (First, Middle, Last) Harry Thomas Loveridge | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Mona Charlotte Fedders | | | |
| 19a. INFORMANT'S NAME (Type/Print) Timothy S. Cheche | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 775 Eagles Court Apt. 2B Westminster, MD 21158 | | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Meadow Branch Cemetery 7/7 | | | |
| 20c. LOCATION — City or Town, State Westminster, MD | | | | 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Shanda L Lemmer | | | |
| 22. NAME AND ADDRESS OF FACILITY Myers Funeral Home 91 Willis Street, Westminster, MD 21157 | | | | 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. BREAST CANCER DUE TO (OR AS A CONSEQUENCE OF): a. BREAST CANCER b. c. d. Approximate Interval Between Onset and Death 4 YRS | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO | | | | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | |
| 26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | 27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | | |
| 28a. DATE OF INJURY (Month, Day, Year) | | | | 28b. TIME OF INJURY M | | | |
| 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | 28d. DESCRIBE HOW INJURY OCCURED | | | |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | 29b. SIGNATURE AND TITLE OF CERTIFIER Samuel Zyglar, M.D. | | | |
| 29c. LICENSE NUMBER 035606 | | | | 29d. DATE SIGNED (Month, Day, Year) 7/5/95 | | | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type/Print) Samuel Zyglar, M.D. 21 Crossroads Drive, Owings Mills, MD 21117 | | | | 31. DATE FILED (Month, Day, Year) JUL 06 1995 | | | |
| 32. REGISTRAR'S SIGNATURE Julia Ancher-Rodall | | | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 21928

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|---|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) LOIS ETHEL COSSENTINO | | | | 2. DATE OF DEATH MONTH DAY YEAR July 5, 1995 | | 3. TIME OF DEATH 12 05 A M | |
| 4. SOCIAL SECURITY NUMBER 213-20-1300 | | 5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 69 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) Feb. 21, 1926 | |
| 9a. FACILITY NAME (If not institution, give street and number) Meridian - Franklin Woods | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Baltimore | | 9c. COUNTY OF DEATH Baltimore | |
| 10a. STATE Maryland | | | | 10b. COUNTY Harford | | 10c. CITY, TOWN OR LOCATION Edgewood | |
| 10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | | | | |
| 10e. STREET AND NUMBER 1204 Janet Dr. | | | | 10f. ZIP CODE 21040 | | 10g. CITIZEN OF WHAT COUNTRY? USA | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Homemaker | | 16b. KIND OF BUSINESS/INDUSTRY Home | | | |
| 17. FATHER'S NAME (First, Middle, Last) Gustave --- Foltz | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Mary Ethel Bishop | | | |
| 19a. INFORMANT'S NAME (Type/Print) William C. Cossentino | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1204 Janet Dr., Edgewood, Md. 21040 | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Holly Hill Memorial Gardens 7-8-95 Baltimore, Md. | | 20c. LOCATION — City or Town, State | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i> | | | | 22. NAME AND ADDRESS OF FACILITY Howard K. McComas III Funeral Home, P.A. 1317 Cokesbury Rd., Abingdon, Md. 21009 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. METASTATIC COLON CANCER DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | | Approximate Interval Between Onset and Death SIX WEEKS |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| | | 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER Carol Richardson MD | | | | 29c. LICENSE NUMBER D46304 | | 29d. DATE SIGNED (Month, Day, Year) July 6, 1995 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) CAROL RICHARDSON MD, 9000 FRANKLIN SQUARE DRIVE, BALTIMORE MD 21237 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JUL 06 1995 | | | | 32. REGISTRAR'S SIGNATURE <i>[Signature]</i> | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

amended #10a, 10b, 10c, 10e + 10f, 7/12/95. Harford County SKB
95 21929

1 - FOR
STATE
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) Charles Allebrand Conlin | | | | 2. DATE OF DEATH MONTH July DAY 3 YEAR 1995 | | 3. TIME OF DEATH 10:45 A M | |
| 4. SOCIAL SECURITY NUMBER 177-03-2082 | | 5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 84 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) June 5, 1911 | |
| 8. BIRTHPLACE (State or Foreign Country) Pennsylvania | | | | 9a. FACILITY NAME (If not institution, give street and number) Bel Forest Nursing Home | | 9b. CITY, TOWN OR LOCATION OF DEATH Forest Hill | |
| 9c. COUNTY OF DEATH Harford | | | | 10a. STATE FLORIDA Maryland | | 10b. COUNTY BREVARD Harford | |
| 10c. CITY, TOWN OR LOCATION Bel Air MELBOURNE | | | | 10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 10e. STREET AND NUMBER 4441 STACK BLVD 2007 Cypress Drive | |
| 10f. ZIP CODE 21015 32901 | | | | 10g. CITIZEN OF WHAT COUNTRY? USA | | 11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES WWII & Korean | | | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | | |
| 14. RACE — American Indian, Black, White, etc. Specify: White | | | | 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 5+ College (1-4 or 5+) U.S. Army | | | |
| 16. KIND OF BUSINESS/INDUSTRY U.S. Government | | | | 17. FATHER'S NAME (First, Middle, Last) John A. Conlin | | | |
| 18. MOTHER'S NAME (First, Middle, Maiden Surname) Hettie (U/K) Allebrand | | | | 19a. INFORMANT'S NAME (Type/Print) Sharon A. Kellerman | | | |
| 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2007 Cypress Drive, Bel Air, Md. 21015 | | | | 20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | |
| 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) R. A. Ferris & Co., Inc. 7/5/95 | | | | 20c. LOCATION — City or Town, State W. Chester, PA | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Stephen A. Neely | | | | 22. NAME AND ADDRESS OF FACILITY Howard K. McComas III Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Md. 21009 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Endstage emphysema DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | | | | |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | | | | |
| 26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | |
| 27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | | | | | | |
| 28a. DATE OF INJURY (Month, Day, Year) July 3, 1995 | | | | | | | |
| 28b. TIME OF INJURY M | | | | | | | |
| 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | | | | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | | | | | | |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | | | | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| 29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER Linda Freilich | | | | | | | |
| 29c. LICENSE NUMBER D28339 | | | | | | | |
| 29d. DATE SIGNED (Month, Day, Year) July 3, 1995 | | | | | | | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) LINDA FREILICH 101E Wheel Road Bel Air Md 21015 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JUL 06 1995 | | | | | | | |
| 32. REGISTRAR'S SIGNATURE John A. Neely | | | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 21930

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|---|--|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last) <i>Rebecca Davis</i> | | | | 2. DATE OF DEATH MONTH DAY YEAR <i>June 19, 1995</i> | | 3. TIME OF DEATH <i>901 P</i> | |
| 4. SOCIAL SECURITY NUMBER <i>578-28-6455</i> | | 5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) <i>75</i> YRS. | | 7. DATE OF BIRTH (Month, Day, Year) <i>July 16, 1919</i> | |
| 9a. FACILITY NAME (If not institution, give street and number) <i>PRINCE GEORGES HOSPITAL</i> | | | | 9b. CITY, TOWN OR LOCATION OF DEATH <i>CHEVERLY</i> | | 9c. COUNTY OF DEATH <i>PRINCE GEORGES</i> | |
| 10a. STATE <i>MARYLAND</i> | | 10b. COUNTY <i>PRINCE GEORGES</i> | | 10c. CITY, TOWN OR LOCATION <i>HYATTSVILLE</i> | | 10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | |
| 10e. STREET AND NUMBER <i>7615 ALLENDALE CIRCLE</i> | | | | 10f. ZIP CODE <i>20785</i> | | 10g. CITIZEN OF WHAT COUNTRY? <i>USA</i> | |
| 11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: <i>BLACK</i> | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <i>UNKNOWN</i> College (1-4 or 5+) <i>College (1-4 or 5+)</i> | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <i>HOUSEKEEPING</i> | | 16b. KIND OF BUSINESS/INDUSTRY <i>GOVERNMENT</i> | | | |
| 17. FATHER'S NAME (First, Middle, Last) <i>STEVEN GREEN</i> | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) <i>SUZANNA BARKER</i> | | | |
| 19a. INFORMANT'S NAME (Type/Print) <i>SARAH SINKFIELD</i> | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>7615 ALLENDALE CIRCLE HYATTSVILLE, MD 20785</i> | | | |
| 20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <i>CHESAPEAKE CREMATORY</i> | | 20c. DATE <i>6-23</i> | | 20d. LOCATION — City or Town, State <i>BELTSVILLE, MD 20705</i> | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Kimberly C Buscose-Tonic</i> | | | | 22. NAME AND ADDRESS OF FACILITY <i>J.B. JENKINS FUNERAL HOME 7474 LANDOVER ROAD LANDOVER, MD 20785</i> | | | |
| 23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Acute atherosclerotic coronary cardiovascular disease</i> DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. | | | | | | | Approximate Interval Between Onset and Death |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Stroke, dementia, bedridden</i> | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | | | | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/> | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY <i>M</i> | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | | | 29. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER <i>Augusta P. Rodriguez MD</i> | | | | 29c. LICENSE NUMBER <i>D21230</i> | | 29d. DATE SIGNED (Month, Day, Year) <i>June 20, 1995</i> | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type/Print) <i>Augusta P. Rodriguez MD, 5709 Rappahannock Ct. Sp. Md 20748</i> | | | | | | | |
| 31. DATE FILED (Month, Day, Year) <i>JUN 26 1995</i> | | | | 32. REGISTRAR'S SIGNATURE <i>John Davidson-Randall</i> | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

P.O. BOX 68760

DIVISION OF VITAL RECORDS

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 21931

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|--|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) Stasia De Bibanco | | | | 2. DATE OF DEATH MONTH DAY YEAR June 24, 1995 | | 3. TIME OF DEATH 9:20 PM M | |
| 4. SOCIAL SECURITY NUMBER 564 28 6761 | | 5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 94 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) Feb. 11, 1901 | |
| 8. BIRTHPLACE (State or Foreign Country) California | | | | 9a. FACILITY NAME (If not institution, give street and number) Crofton Convalescent Center | | 9b. CITY, TOWN OR LOCATION OF DEATH Crofton | |
| 9c. COUNTY OF DEATH Anne Arundel | | | | 10a. STATE Maryland | | 10b. COUNTY Anne Arundel | |
| 10c. CITY, TOWN OR LOCATION Gambrills | | | | 10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 10e. STREET AND NUMBER 1513 Branchwood Terrace | |
| 10f. ZIP CODE 21054 | | | | 10g. CITIZEN OF WHAT COUNTRY? United States | | 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced | |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES No | | | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: No | | 14. RACE — American Indian, Black, White, etc. Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) _____ | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Secretary | | 16b. KIND OF BUSINESS/INDUSTRY U.S. Government | |
| 17. FATHER'S NAME (First, Middle, Last) Ralph Coggeshall | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Alice A. Schaffer | | | |
| 19a. INFORMANT'S NAME (Type/Print) Clinton L. Pallister | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1513 Branchwood Terrace Gambrills Md. 21054 | | | |
| 20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) _____ | | | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Metropolitan Crematory 6/26/95 | | 20c. LOCATION — City or Town, State Alexandria Virginia | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Robert E. Evans Pres. | | | | 22. NAME AND ADDRESS OF FACILITY Robert E. Evans Funeral Home, P.A. 16000 Annapolis Rd. Bowie Md. 20715 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Left ventricular failure DUE TO (OR AS A CONSEQUENCE OF): b. Anterolateral Coronary artery DUE TO (OR AS A CONSEQUENCE OF): c. _____ DUE TO (OR AS A CONSEQUENCE OF): d. _____ Approximate Interval Between Onset and Death Hours Days | | | | | | | |
| 24. PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) _____ | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | | | 28a. DATE OF INJURY (Month, Day, Year) 28b. TIME OF INJURY M 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | 29b. SIGNATURE AND TITLE OF CERTIFIER Max C. Frank MD | | 29c. LICENSE NUMBER D01828 | |
| 29d. DATE SIGNED (Month, Day, Year) 6/26/95 | | | | 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Max C. Frank MD 2550 Ritchie Hwy - Glen Burnie MD 21061 | | | |
| 31. DATE FILED (Month, Day, Year) JUL 06 1995 | | | | 32. REGISTRAR'S SIGNATURE John A. ... | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Demarr

95 21932

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|---|--|--|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) ANNIE M. DEMARR | | | | 2. DATE OF DEATH MONTH JULY DAY 3 YEAR 1995 | | 3. TIME OF DEATH 10:10 P M | |
| 4. SOCIAL SECURITY NUMBER 577-01-3545 | | 5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 80 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 9/12/14 | |
| 9a. FACILITY NAME (If not Institution, give street and number) SOUTHERN MARYLAND HOSPITAL | | | | 9b. CITY, TOWN OR LOCATION OF DEATH CLINTON | | 9c. COUNTY OF DEATH PRINCE GEORGES | |
| 10a. STATE Maryland | | 10b. COUNTY Prince George's | | 10c. CITY, TOWN OR LOCATION Suitland | | 10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 10e. STREET AND NUMBER 4008 St. Barnabas Rd. | | | | 10f. ZIP CODE 20746 | | 10g. CITIZEN OF WHAT COUNTRY? USA | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) 12th | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Secretary | | 16b. KIND OF BUSINESS/INDUSTRY P.G. Co. School System | |
| 17. FATHER'S NAME (First, Middle, Last) Unknown Bostick | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Mary Brewer | | | |
| 19a. INFORMANT'S NAME (Type/Print) Joan E. Goodrick | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 547 Florida Ave. T-3 Herndon, Va. 22070 | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Washington Nat. Cemetery 7/6/95 | | 20c. LOCATION — City or Town, State Suitland, Md. | | 20d. DATE 7/6/95 | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>George P. Kalas</i> | | | | 22. NAME AND ADDRESS OF FACILITY George P. Kalas Funeral Home 6160 Oxon Hill Rd. Oxon Hill, Md. 20745 | | | |
| 23. PART I. Enter the diseases, or complications, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. — Congestive heart failure DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): Approximate interval between Onset and Death 2-3 years | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. — Chronic Renal Failure — Malnutrition — Chronic Anemia | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER <i>Sam T. [Signature]</i> | | | | 29c. LICENSE NUMBER D34274 | | 29d. DATE SIGNED (Month, Day, Year) 7.4.95 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) E. Tellow, MD 7700 OLD BRANCH AVE CLINTON MD 20735 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JUL 06 1995 | | | | 32. REGISTRAR'S SIGNATURE <i>John A. [Signature]</i> | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 21933

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|--------------------------|--|--|--|---|--|
| 1. DECEASED'S NAME (First, Middle, Last) DOUGLAS R DICK | | | | 2. DATE OF DEATH MONTH JUNE DAY 16 YEAR 1995 | | 3. TIME OF DEATH 2:00 P M | |
| 4. SOCIAL SECURITY NUMBER 219-48-1343 | | 5. SEX 1 M 2 F | | 6. AGE (In yrs. last birthday) 48 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) Nov. 16, 1946 | |
| 8. BIRTHPLACE (State or Foreign Country) Washington, DC | | | | 9a. FACILITY NAME (If not institution, give street and number) Laurel Regional Hospital | | 9b. CITY, TOWN OR LOCATION OF DEATH Laurel | |
| 9c. COUNTY OF DEATH PRINCE GEORGE'S | | | | 10a. STATE Maryland | | 10b. COUNTY Prince George's | |
| 10c. CITY, TOWN OR LOCATION Hyattsville | | | | 10d. INSIDE CITY LIMITS? 1 YES 2 NO | | 10e. STREET AND NUMBER 5711 31st Avenue | |
| 10f. ZIP CODE 20782 | | | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | | 11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced | |
| 12. WAS DECEASED EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES | | | | 13. WAS DECEASED OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 YES 2 NO Specify: | | | |
| 14. RACE — American Indian, Black, White, etc. Specify: Chinese | | | | 15. DECEASED'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 | | | |
| 16a. DECEASED'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Florist | | | | 16b. KIND OF BUSINESS/INDUSTRY Mount Rainier Flower Shop | | | |
| 17. FATHER'S NAME (First, Middle, Last) Walter C. Dick | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Florence Chu | | | |
| 19a. INFORMANT'S NAME (Type/Print) Nancy A. Dick | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5711 31st Avenue, Hyattsville, Maryland 20782 | | | |
| 20a. METHOD OF DISPOSITION 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) | | | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Fort Lincoln Cemetery 06/20/95 | | | |
| 20c. LOCATION — City or Town, State Brentwood, Maryland | | | | 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Henry S. Ford</i> | | | |
| 22. NAME AND ADDRESS OF FACILITY Francis Gasch's Sons Funeral Home, P.A. 4739 Baltimore Ave., Hyattsville, MD 20781 | | | | 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → e. HYPOXEMIA DUE TO (OR AS A CONSEQUENCE OF): Sequitely ill conditions, if any, leading to underlying cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST { d. COR PULMONALE, ACUTE DUE TO (OR AS A CONSEQUENCE OF): PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. BILATERAL LOBAR PNEUMONIA | | | |
| 24a. WAS AN AUTOPSY PERFORMED? 1 YES 2 NO | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO | | | |
| 25. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 Inpatient 2 ER/Outpatient 3 DOA OTHER: 4 Nursing Home 5 Residence 6 Other (Specify) | | | |
| 27. MANNER OF DEATH 1 Natural 2 Accident 3 Suicide 4 Homicide 5 Pending Investigation 6 Could not be determined | | | | 28a. DATE OF INJURY (Month, Day, Year) 28b. TIME OF INJURY M 28c. INJURY AT WORK? 1 YES 2 NO | | | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | 29a. CERTIFIER (Check only one) 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER <i>S. Berger MD</i> | | | | 29c. LICENSE NUMBER 025925 | | | |
| 29d. DATE SIGNED (Month, Day, Year) June 21, 1995 | | | | 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) J. BERGER #205, 7720 WISCONSIN Ave Bethesda Md 20814 | | | |
| 31. DATE FILED (Month, Day, Year) JUN 28 1995 | | | | 32. REGISTRAR'S SIGNATURE <i>John Davidson</i> | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician to the FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DATE MADE MORE LEGIBLE JK.

95 21934

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|---|--|--|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) MARGARET Garnett DRECHSLER | | | | 2. DATE OF DEATH MONTH DAY YEAR JUNE 27 1995 | | 3. TIME OF DEATH 6:40 P M | |
| 4. SOCIAL SECURITY NUMBER 578-28-6279 | | 5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 68 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) Oct 17, 1926 | |
| 8. BIRTHPLACE (State or Foreign Country) Virginia | | | | 9a. FACILITY NAME (If not Institution, give street and number) 4769 Homer Avenue | | 9b. CITY, TOWN OR LOCATION OF DEATH Suitland | |
| 9c. COUNTY OF DEATH Prince George's | | | | 10a. STATE Maryland | | 10b. COUNTY Prince George's | |
| 10c. CITY, TOWN OR LOCATION Suitland | | | | 10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 10e. CITIZEN OF WHAT COUNTRY? United States | |
| 11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | |
| 14. RACE — American Indian, Black, White, etc. Specify: White | | | | 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 11th College (1-4 or 5+) Housewife | | 16. KIND OF BUSINESS/INDUSTRY At Home | |
| 17. FATHER'S NAME (First, Middle, Last) Jesse J. Estep | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Ethie Allen | | | |
| 19a. INFORMANT'S NAME (Type/Print) William F. Drechsler | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4769 Homer Ave, Suitland, Md 20746 | | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Washington National Cem June 30, 1995 | | 20c. LOCATION — City or Town, State Suitland, Md | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | | | | 22. NAME AND ADDRESS OF FACILITY Lee Funeral Home, Inc. 6633 Old Alexander Ferry Rd., Clinton, Md. | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → CARDIOPULMONARY ARREST Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. CONGESTIVE HEART FAILURE c. CONGESTIVE HEART FAILURE d. CONGESTIVE HEART FAILURE | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | 29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER | | | | 29c. LICENSE NUMBER D27259 | | 29d. DATE SIGNED (Month, Day, Year) 6/28/95 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) David T. Isaacs, M.D., 5001 Silver Hill Road, #101, Suitland, Md. 20746 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JUL 06 1995 | | | | 32. REGISTRAR'S SIGNATURE | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 21935

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|---|--|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last) Mary Gladys Dickerson | | | | 2. DATE OF DEATH MONTH DAY YEAR July 6 95 | | 3. TIME OF DEATH 8:12 A M | |
| 4. SOCIAL SECURITY NUMBER 213-38-0033 | | 5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 91 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) Jan. 15, 1904 | |
| 9a. FACILITY NAME (If not institution, give street and number) Fahrney-Keedy Brethren Home | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Boonsboro | | 9c. COUNTY OF DEATH Washington | |
| RESIDENCE OF DECEDENT | | | | | | | |
| 10a. STATE Maryland | | 10b. COUNTY Washington | | 10c. CITY, TOWN OR LOCATION Boonsboro | | 10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 10e. STREET AND NUMBER 8507 Mapleville Rd. | | | | 10f. ZIP CODE 21713 | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 11. MARITAL STATUS 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 11 College (1-4 or 5+) 5+ | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) teacher/supervisor | | 16b. KIND OF BUSINESS/INDUSTRY public school | | | |
| 17. FATHER'S NAME (First, Middle, Last) Christopher C. Dickerson | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Mary Magdaline Marshall | | | |
| 19a. INFORMANT'S NAME (Type/Print) Reva M. Blacksten | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 429 Clear Ridge Rd. Union Bridge, MD 21791 | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Pipe Creek Cemetery 7/9 | | 20c. LOCATION — City or Town, State nr. Linwood, MD | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Catharine D. Hartzler</i> | | | | 22. NAME AND ADDRESS OF FACILITY D.D. Hartzler & Sons Union Bridge, MD | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Cerebrovascular Accident DUE TO (OR AS A CONSEQUENCE OF): b. Arterio-sclerotic Cardiovascular Disease DUE TO (OR AS A CONSEQUENCE OF): c. with Arterio-sclerotic DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | | Approximate Interval Between Onset and Death 2 months |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28d. DESCRIBE HOW INJURY OCCURRED | | | |
| 29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER <i>— [Signature] MD</i> | | | | 29c. LICENSE NUMBER 018019 | | 29d. DATE SIGNED (Month, Day, Year) July 6, 1995 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) VASANT DATTA, MD 334 MILL ST HAGERSTOWN, MD 21740 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JUL 07 1995 | | 32. REGISTRAR'S SIGNATURE <i>Julia Shuler Randall</i> | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Amended #6 7/14/95 ELM P.G.C.

95 21936

ITEMS: 23 PART I, 27, 28a-f, PER MEO FILM G-725 7/31/95 t.t

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|---|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) STERLING A. EVANS, JR. | | | | 2. DATE OF DEATH MONTH DAY YEAR JUNE 28 1995 | | 3. TIME OF DEATH HOURS MIN. 12:31 A | |
| 4. SOCIAL SECURITY NUMBER 219-78-1445 | | 5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 35.36 YRS. MONTHS DAYS HOURS MIN. | | 7. DATE OF BIRTH (Month, Day, Year) June 18, 1959 | |
| 8. FACILITY NAME (If not institution, give street and number) PRINCE GEORGES HOSPITAL CENTER | | | | 9. CITY, TOWN OR LOCATION OF DEATH CHEVERLY | | 10. COUNTY OF DEATH PRINCE GEORGES | |
| 10a. STATE Maryland | | 10b. COUNTY Prince George's | | 10c. CITY, TOWN OR LOCATION Mt. Rainier | | 10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 10e. STREET AND NUMBER 4310 37th Street | | | | 10f. ZIP CODE 20712 | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 11. MARITAL STATUS 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Plumber | | 16b. KIND OF BUSINESS/INDUSTRY Plumbing | | | |
| 17. FATHER'S NAME (First, Middle, Last) Sterling A. Evans, Sr. | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Irene May Eaton | | | |
| 19a. INFORMANT'S NAME (Type/Print) Sterling A. Evans, Sr. | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7436 Buchanan Drive, King George, Virginia 22485 | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Fort Lincoln Cemetery 07/03/95 | | 20c. LOCATION — City or Town, State Brentwood, Maryland | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Charles F. Bell | | | | 22. NAME AND ADDRESS OF FACILITY Francis Gasch's Sons Funeral Home, P.A. 4739 Baltimore Ave., Hyattsville, MD 20781 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. NARCOTIC AND ALCOHOL INTOXICATION DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | Approximate Interval Between Onset and Death | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | | | DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/> | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? XX YES 2 <input type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input checked="" type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) FOUND ON 6/28/95 | | 28b. TIME OF INJURY 12:15 A | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| | | 28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) FOUND AT HOME | | 28e. DESCRIBE HOW INJURY OCCURRED UNKNOWN | | | |
| | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) 4310 37TH STREET BALTIMORE, MARYLAND | | | | | |
| 29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER [Signature] | | | | 29c. LICENSE NUMBER O.C.M.E. | | 29d. DATE SIGNED (Month, Day, Year) JUNE 28, 1995 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) David R Fowler 111 Penn Street, Baltimore, Maryland 21201 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JUL 06 1995 [Signature] | | | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 21937

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | |
|--|--|---|--|--|--|--|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) <i>Grace E. Everette</i> | | | | 2. DATE OF DEATH MONTH DAY YEAR <i>June 29 1995</i> | | | | 3. TIME OF DEATH <i>12:00p</i> | |
| 4. SOCIAL SECURITY NUMBER <i>577-26-3848</i> | | 5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) <i>77</i> YRS. | | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS. HOURS MIN. | |
| 7. DATE OF BIRTH (Month, Day, Year) <i>July 13, 1917</i> | | | | 8. BIRTHPLACE (State or Foreign Country) <i>North Carolina</i> | | | | | |
| 9a. FACILITY NAME (If not institution, give street and number) <i>SOUTHERN MARYLAND HOSPITAL</i> | | | | 9b. CITY, TOWN OR LOCATION OF DEATH <i>CLINTON</i> | | | | 9c. COUNTY OF DEATH <i>PRINCE GEORGES</i> | |
| 10a. STATE <i>MARYLAND</i> | | | | 10b. COUNTY <i>PRINCE GEORGES</i> | | | | 10c. CITY, TOWN OR LOCATION <i>UPPER MARLBORO</i> | |
| 10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | | | | | | |
| 10e. STREET AND NUMBER <i>10828 OLD INDIAN HEAD ROAD</i> | | | | 10f. ZIP CODE <i>20772</i> | | | | 10g. CITIZEN OF WHAT COUNTRY? <i>UNITED STATES</i> | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | | | 14. RACE — American Indian, Black, White, etc. Specify: <i>BLACK</i> | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <i>2</i> College (1-4 or 5+) <i>2</i> | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <i>COSMETOLOGIST</i> | | | | 16b. KIND OF BUSINESS/INDUSTRY <i>BEAUTY SHOP</i> | |
| 17. FATHER'S NAME (First, Middle, Last) <i>JOSEPH BENTON</i> | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) <i>ANNIE HILL</i> | | | | | |
| 19a. INFORMANT'S NAME (Type/Print) <i>GEORGE M. EVERETTE</i> | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>10828 OLD INDIAN HEAD RD., UPPER MARLBORO, MD 20772</i> | | | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <i>MD ST VETERANS CEMETERY</i> | | DATE <i>7/5</i> | | 20c. LOCATION — City or Town, State <i>CHELTENHAM, MARYLAND</i> | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Alex S. Pope Jr</i> | | | | 22. NAME AND ADDRESS OF FACILITY <i>ALEXANDER S. POPE FUNERAL HOMES 5538 MARLBORO PIKE, FORESTVILLE, MD 20747</i> | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Aspiration</i> a. DUE TO (OR AS A CONSEQUENCE OF): b. <i>Protracted Nausea/Vomiting</i> c. DUE TO (OR AS A CONSEQUENCE OF): d. Approximate Interval Between Onset and Death <i>24h.</i> <i>24h.</i> | | | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Dementia</i> | | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | | | | | | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/> | | | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide 3 <input type="checkbox"/> Homicide 4 <input type="checkbox"/> Could not be determined | | | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY <i>M</i> | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28d. DESCRIBE HOW INJURY OCCURRED | | | | | |
| 28e. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | | | | | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER <i>O. L. Haywood</i> | | | | 29c. LICENSE NUMBER <i>D26352</i> | | | | 29d. DATE SIGNED (Month, Day, Year) <i>6/30/95</i> | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>Oswald Haye M.D. 9131 Piscataway Rd #540 Clinton MD 20735</i> | | | | | | | | | |
| 31. DATE FILED (Month, Day, Year) <i>JUL 07 1995</i> | | | | 32. REGISTRAR'S SIGNATURE <i>John Davidson Randall</i> | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

4 0/4

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 21938

1 - FOR
STATE
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|---|--|--|--|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last) Laura Esposito | | | | 2. DATE OF DEATH MONTH DAY YEAR June 28, 1995 | | 3. TIME OF DEATH 1745 Hrs. M | |
| 4. SOCIAL SECURITY NUMBER 044-07-1246 | | 5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 78 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) July 18, 1916 | |
| 9a. FACILITY NAME (If not institution, give street and number) Shady Grove Adventist Hospital | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Rockville | | 9c. COUNTY OF DEATH Montgomery County | |
| RESIDENCE OF DECEDENT | | | | | | | |
| 10a. STATE Connecticut | | 10b. COUNTY New Haven | | 10c. CITY, TOWN OR LOCATION Ansonia | | 10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 10e. STREET AND NUMBER 34 Arch Street | | | | 10f. ZIP CODE 06401 | | 10g. CITIZEN OF WHAT COUNTRY? United States of America | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Homemaker | | 16b. KIND OF BUSINESS/INDUSTRY Own Home | |
| 17. FATHER'S NAME (First, Middle, Last) Emanuel LaForte | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Maria Corsello | | | |
| 19a. INFORMANT'S NAME (Type/Print) Judith Sachs | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11921 Appalooga Way, North, Potomac, Maryland | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Pine Grove Cemetery | | 20c. LOCATION — City or Town, State Ansonia, Connecticut | | 20d. DATE 7/1 1995 | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE #M00690 <i>Donald A. Carson</i> | | | | 22. NAME AND ADDRESS OF FACILITY Jenkins-King Funeral Home 12 Franklin Street, Ansonia, Connecticut | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | | a. <i>Congestive heart failure</i> | | | | | Approximate Interval Between Onset and Death 16 Hours |
| | | b. <i>Dilated cardiomyopathy</i> | | | | | |
| | | c. | | | | | |
| | | d. | | | | | |
| 24. SEQUENTIALLY LIST CONDITIONS, IF ANY, LEADING TO IMMEDIATE CAUSE. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | 28g. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER M. CHORDRY | | | | 29c. LICENSE NUMBER D42222 | | 29d. DATE SIGNED (Month, Day, Year) July 3rd 1995 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) M. CHORDRY 11120 New Hampshire Ave Silver Spring MD 20904 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JUL 07 1995 | | | | 32. REGISTRAR'S SIGNATURE <i>John Davidson Randall</i> | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 21939

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) CHARLES WILLIAM Esham | | | | 2. DATE OF DEATH MONTH DAY YEAR June 28 1995 | | 3. TIME OF DEATH 4:57 PM | |
| 4. SOCIAL SECURITY NUMBER 215-62-2408 | | 5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 42 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) January 25, 1953 | |
| 8. FACILITY NAME (If not institution, give street and number) PENINSULA REGIONAL MEDICAL CENTER | | | | 9b. CITY, TOWN OR LOCATION OF DEATH SALISBURY | | 9c. COUNTY OF DEATH WICOMICO | |
| RESIDENCE OF DECEDENT | | | | | | | |
| 10a. STATE Maryland | | 10b. COUNTY Wicomico | | 10c. CITY, TOWN OR LOCATION Salisbury | | 10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input type="checkbox"/> NO | |
| 10e. STREET AND NUMBER Lemon Hill Lane | | | | 10f. ZIP CODE 21801 | | 10g. CITIZEN OF WHAT COUNTRY? USA | |
| 11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (13-16 or 17+) 2 | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Police Officer | | 16b. KIND OF BUSINESS/INDUSTRY Law Enforcement | | | |
| 17. FATHER'S NAME (First, Middle, Last) Charles William Esham | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Jackie Dennis | | | |
| 19a. INFORMANT'S NAME (Type/Print) Lawrence D. Esham | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13159 Backbone Rd., Princess Anne, MD 21853 | | | |
| 20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Salisbury Crematory | | DATE | | 20c. LOCATION — City or Town, State Salisbury, MD | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>W.R. Hall</i> | | | | 22. NAME AND ADDRESS OF FACILITY Holloway Funeral Home 501 Snow Hill Rd., Salisbury, MD 21801 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Malignant Melanoma, metastatic to Brain. DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): Approximate Interval Between Onset and Death 10 years | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| | | 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER <i>James E. Martin, M.D.</i> | | | | 29c. LICENSE NUMBER 030690 | | 29d. DATE SIGNED (Month, Day, Year) 6/29/95 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) James E. Martin, M.D., 145 E. Carroll St., Salisbury, MD | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JUN 30 1995 | | 32. REGISTRAR'S SIGNATURE <i>John Andrew Randall</i> | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 687600 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 21940

1 - FOR
STATE
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH REG. NO.

| | | | | | | | |
|---|--|--|--|---|--------------------------------|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) <i>Dorothy Marie Fahey</i> | | | | 2. DATE OF DEATH MONTH DAY YEAR <i>June 19, 1995</i> | | 3. TIME OF DEATH <i>5:50 p M</i> | |
| 4. SOCIAL SECURITY NUMBER <i>163-07-6647</i> | | 5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | 6. AGE (In yrs. last birthday) <i>82</i> YRS. | IF UNDER 1 YEAR MONTHS DAYS | IF UNDER 24 HRS. HOURS MIN. | 7. DATE OF BIRTH (Month, Day, Year) <i>Feb. 2, 1912</i> | |
| 8. BIRTHPLACE (State or Foreign Country) <i>Pennsylvania</i> | | | | 9a. FACILITY NAME (If not Institution, give street and number) <i>Doctors Community Hospital</i> | | 9b. CITY, TOWN OR LOCATION OF DEATH <i>Lanham</i> | |
| 9c. COUNTY OF DEATH <i>Prince Georges</i> | | | | 10a. STATE <i>Maryland</i> | | 10b. COUNTY <i>Prince George's</i> | |
| 10c. CITY, TOWN OR LOCATION <i>College Park</i> | | | | 10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 10e. STREET AND NUMBER <i>5013 Quebec Street</i> | |
| 10f. ZIP CODE <i>20740</i> | | | | 10g. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i> | | 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES <i>8/14/43 - 11/19/45</i> | | | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: <i>White</i> | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <i>8</i> College (1-4 or 5+) <i>College (1-4 or 5+)</i> | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <i>Homemaker</i> | | 16b. KIND OF BUSINESS/INDUSTRY <i>Own Home</i> | |
| 17. FATHER'S NAME (First, Middle, Last) <i>John J. Doyle</i> | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) <i>Elizabeth McGinnis</i> | | | |
| 19a. INFORMANT'S NAME (Type/Print) <i>William Fahey</i> | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>3135 North 17th Street, Arlington, Virginia 22201</i> | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <i>Gate of Heaven Cemetery 06/21/95</i> | | 20c. LOCATION — City or Town, State <i>Silver Spring, Maryland</i> | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>W.B. G...</i> | | | | 22. NAME AND ADDRESS OF FACILITY <i>Francis Gasch's Sons Funeral Home, P.A. 4739 Baltimore Ave., Hyattsville, MD 20781</i> | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Malignant Fibrous Histiocytoma of Bone</i> Approximate Interval Between Onset and Death <i>6 weeks</i> Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST a. DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Pneumonia</i> <i>Urinary tract infection</i> DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY <i>M</i> | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28d. DESCRIBE HOW INJURY OCCURRED | | | | | |
| 28e. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER <i>George C. Hajjar, Jr.</i> | | | | 29c. LICENSE NUMBER <i>039550</i> | | 29d. DATE SIGNED (Month, Day, Year) <i>6-20-95</i> | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>George C. Hajjar, Jr. M.D. 4850 Forbes Blvd. Lanham, Md. 20706</i> | | | | | | | |
| 31. DATE FILED (Month, Day, Year) <i>JUN 26 1995</i> | | | | 32. REGISTRAR'S SIGNATURE <i>John A. ...</i> | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION


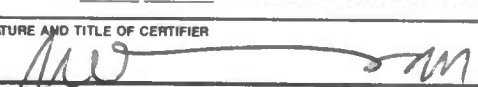

BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 21941

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|--|--|---|--|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last) JOHN W FELDER SR. | | | | 2. DATE OF DEATH MONTH JUNE DAY 13 YEAR 1995 | | 3. TIME OF DEATH 9:00 A M | |
| 4. SOCIAL SECURITY NUMBER 230-16-6200 | | 5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F X | | 6. AGE (In yrs. last birthday) 73 YRS. | | 7. DATE OF BIRTH MONTH JULY DAY 3 YEAR 1921 | |
| 9a. FACILITY NAME (If not institution, give street and number) Southern Md. Hospital | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Waldorf | | 9c. COUNTY OF DEATH P, G, | |
| 10a. STATE Md, | | 10b. COUNTY P, G, | | 10c. CITY, TOWN OR LOCATION Morningside | | 10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 10a. STREET AND NUMBER 4304 Offut Drive | | | | 10f. ZIP CODE 20746 | | 10g. CITIZEN OF WHAT COUNTRY? U. S. A. | |
| 11. MARITAL STATUS 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: Black | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 8ht Grade College (1-4 or 5+) College (1-4 or 5+) | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Laborer | | 16b. KIND OF BUSINESS/INDUSTRY | | | |
| 17. FATHER'S NAME (First, Middle, Last) Moses Felder | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Mary Robinson | | | |
| 19a. INFORMANT'S NAME (Type/Print) Maggie Felder | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12000 Hillendale Ter 1 Mitchscille, M. d. 20746 | | | |
| 20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Harmony Memoria Cemetery | | 20c. LOCATION — City or Town, State Landover, Md. | | 20d. DATE | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE  446 | | | | 22. NAME AND ADDRESS OF FACILITY Sam Butler Funeral Service 716 Kennedy St, NW, Wash., DC | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → PNEUMONIA DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. | | | | | | | Approximate interval Between Onset and Death DAYS |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER  | | | | 29c. LICENSE NUMBER D-18545 | | 29d. DATE SIGNED (Month, Day, Year) JUNE 13, 1995 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Philip Wisotsky M.D. 6188 Oxon Hill Road # 807 Oxon Hill, Maryland 20745 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JUN 26 1995 | | 32. REGISTRAR'S SIGNATURE  | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 21942

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) GREGORY ANTHONY FOSTER | | | | 2. DATE OF DEATH MONTH DAY YEAR JUNE 23, 1995 | | 3. TIME OF DEATH 06:15 A M | |
| 4. SOCIAL SECURITY NUMBER 579-90-5686 | | 5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 21 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) JUN 21, 1974 | |
| 9a. FACILITY NAME (If not institution, give street and number) PRINCE GEORGES HOSPITAL | | | | 9b. CITY, TOWN OR LOCATION OF DEATH CHEVERLY | | 9c. COUNTY OF DEATH PRINCE GEORGES | |
| 10a. STATE MARYLAND | | | | 10b. COUNTY PRINCE GEORGES | | 10c. CITY, TOWN OR LOCATION UPPER MARLBORO | |
| 10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | | | | |
| 10e. STREET AND NUMBER 8829 EAST GROVE | | | | 10f. ZIP CODE 20772 | | 10g. CITIZEN OF WHAT COUNTRY? UNITED STATES | |
| 11. MARITAL STATUS 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: BLACK | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 12 | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) WARE HOUSEMAN | | 16b. KIND OF BUSINESS/INDUSTRY PRIVATE | | | |
| 17. FATHER'S NAME (First, Middle, Last) GREGORY A. FOSTER, SR. | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) CHERYL BARNES | | | |
| 19a. INFORMANT'S NAME (Type/Print) CHERYL BARNES (MOTHER) | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8829 East Grove, Upper Marlboro, Md. 20772 | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) HARMONY MEMORIAL PARK | | DATE 6/30 | | 20c. LOCATION — City or Town, State LANDOVER, MARYLAND | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Alex S. Pope Jr.</i> M859 | | | | 22. NAME AND ADDRESS OF FACILITY ALEXANDER S. POPE FUNERAL HOMES 5538 Marlboro Pike, Forestville, Md 20747 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Multiple Gun Shot Wounds DUE TO (OR AS A CONSEQUENCE OF): Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST { b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | Approximate Interval Between Onset and Death |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) 6-22-95 | | 28b. TIME OF INJURY 503 PM | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED Subject Shot | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) Roadway | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) 4860 Eastern Lane Snydland P.G. Co. | | | |
| 29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER <i>David R. Fowler</i> | | | | 29c. LICENSE NUMBER OCME | | 29d. DATE SIGNED (Month, Day, Year) JUNE 24, 1995 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) David R. Fowler 111 Penn Street, Baltimore, Maryland 21201 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JUN 26 1995 | | | | 32. REGISTRAR'S SIGNATURE <i>John Davidson Kendall</i> | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 21943

1 - FOR
STATE
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | |
|---|--|---|--|---|--|--|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) Joseph B. Farley | | | | 2. DATE OF DEATH MONTH DAY YEAR June 23 1995 | | 3. TIME OF DEATH 12:22 PM | | | |
| 4. SOCIAL SECURITY NUMBER 173 01 2036 | | 5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 90 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) Feb. 11 1905 | | 8. BIRTHPLACE (State or Foreign Country) Massachusetts | |
| 9a. FACILITY NAME (If not institution, give street and number) Crofton Convalescent Center | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Crofton | | | 9c. COUNTY OF DEATH Anne Arundel | | |
| 10a. STATE Maryland | | | | 10b. COUNTY Prince Georges | | 10c. CITY, TOWN OR LOCATION Bowie | | 10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 10e. STREET AND NUMBER 12733 Holiday Lane | | | | 10f. ZIP CODE 20715 | | 10g. CITIZEN OF WHAT COUNTRY? United States | | | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES WWII | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | | 14. RACE — American Indian, Black, White, etc. Specify: White | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 12 | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Dog Trainer | | | 16b. KIND OF BUSINESS/INDUSTRY Farley School For Dogs | | |
| 17. FATHER'S NAME (First, Middle, Last) Dennis Eugene Farley | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Amy Ashworth | | | | | |
| 19a. INFORMANT'S NAME (Type/Print) Anne Seitz | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12733 Holiday Lane Bowie Maryland 20715 | | | | | |
| 20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Metropolitan Crematory 6-24-95 | | 20c. LOCATION — City or Town, State Alexandria Virginia | | | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Robert E. Evans, Jr. | | | | 22. NAME AND ADDRESS OF FACILITY Robert E. Evans Funeral Home, P.A. 16000 Annapolis Rd. Bowie Md. 20715 | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Respiratory Arrest b. Respiratory Failure c. COPD d. Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST Approximate Interval Between Onset and Death 2 months 25 yr. | | | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED | |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | |
| 29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER Paul S. Rhodes | | | | 29c. LICENSE NUMBER D 22028 | | 29d. DATE SIGNED (Month, Day, Year) 6-23-95 | | | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Paul S. Rhodes m.p. 1667 Crofton Center Crofton Md. | | | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JUN 28 1995 | | | | 32. REGISTRAR'S SIGNATURE John Davidson | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 21944

1 - FOR
STATE
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|---|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) James William Gately, Jr. | | | | 2. DATE OF DEATH MONTH DAY YEAR June 24, 1995 | | 3. TIME OF DEATH 1620 M | |
| 4. SOCIAL SECURITY NUMBER 578-54-6412 | | 5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 54 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) Sept. 6, 1940 | |
| 8. FACILITY NAME (If not institution, give street and number) 1 Cross Woods Drive | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Mechanicsville | | 9c. COUNTY OF DEATH St. Mary's | |
| 10a. STATE Maryland | | 10b. COUNTY St. Mary's | | 10c. CITY, TOWN OR LOCATION Mechanicsville | | 10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| 10e. STREET AND NUMBER 1 Cross Woods Drive | | | | 10f. ZIP CODE 20659 | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 1 College (1-4 or 5+) 1 | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Public Affairs Officer | | 16b. KIND OF BUSINESS/INDUSTRY Naval Research Laboratory | | | |
| 17. FATHER'S NAME (First, Middle, Last) James William Gately, Sr. | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Jean F. Beutjer | | | |
| 19a. INFORMANT'S NAME (Type/Print) Theresa Easter | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 30326 Summit Ct. Mechanicsville, Md. 20659 | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Resurrection Cemetery 6/27/95 | | 20c. LOCATION — City or Town, State Clinton, Maryland | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>George P. Kalas</i> | | | | 22. NAME AND ADDRESS OF FACILITY George P. Kalas Funeral Home 6160 Oxon Hill Rd. Oxon Hill, Md. 20745 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Suicide - GSW Head. DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. | | | | | | | Approximate Interval Between Onset and Death |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | | | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |
| 27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input checked="" type="checkbox"/> Suicide 8 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) 6-24-95 | | 28b. TIME OF INJURY 1620P | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| | | 28d. DESCRIBE HOW INJURY OCCURRED GSW | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) Home - Pick | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) Home | |
| 29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER <i>William D. Boyd II</i> | | | | 29c. LICENSE NUMBER D14285 | | 29d. DATE SIGNED (Month, Day, Year) 6/26/95 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) William D. Boyd II, M.D., 17 Jefferson Street, Leonardtown, Maryland 20650 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JUN 27 1995 | | | | 32. REGISTRAR'S SIGNATURE <i>John Jackson-Randall</i> | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

15

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | | | |
|--|--|---|--|---|--|---|---|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) BRIANA VEE BURNO GENTRY | | | | 2. DATE OF DEATH MONTH JUNE DAY 12 YEAR 1995 | | 3. TIME OF DEATH 10:52 P M | | | | | |
| 4. SOCIAL SECURITY NUMBER 214-21-4243 | | 5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 17 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) February 16, 1978 | | 8. BIRTHPLACE (State or Foreign Country) Washington, D.C. | | | |
| 9a. FACILITY NAME (If not institution, give street and number) 6900 BLOCK ADEL STREET | | | | 9b. CITY, TOWN OR LOCATION OF DEATH SEAT PLEASANT | | | 9c. COUNTY OF DEATH PRINCE GEORGES | | | | |
| 10a. STATE Maryland | | 10b. COUNTY Prince George's | | 10c. CITY, TOWN OR LOCATION Maryland Park | | | 10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | |
| 10e. STREET AND NUMBER 112 Maryland Park Drive | | | | 10f. ZIP CODE 20743 | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | | | | | |
| 11. MARITAL STATUS 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | | 14. RACE — American Indian, Black, White, etc. Specify: Black | | | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) 11th Grade | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Student | | | 16b. KIND OF BUSINESS/INDUSTRY Archbishop Carroll High School | | | | |
| 17. FATHER'S NAME (First, Middle, Last) Robert P. Gentry | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Belle Vee Burno | | | | | | | |
| 19a. INFORMANT'S NAME (Type/Print) Belle Vee Burno Gentry (Mother) | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 112 Maryland Park Drive Maryland Park, Maryland 20743 | | | | | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Mount Olivet Cemetery | | 20c. LOCATION — City or Town, State June 17, 1995 Washington, D.C. | | | | | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i> | | | | 22. NAME AND ADDRESS OF FUNERAL HOME Robbins Funeral Home, Inc. 4339 Hunt Place, N.E. Washington, D.C. 20019 | | | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. MULTIPLE GUNSHOT WOUNDS DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. | | | | | | | | Approximate Interval Between Onset and Death | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) AT SCENE | | | | | | | | | |
| 27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input checked="" type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) 6/12/1995 | | 28b. TIME OF INJURY 9:15 PM | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED SUBJECT SHOT | | | |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) ON STREET | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) 6900 BLOCK ADEL STREET SEAT PLEASANT, PRINCE GEORGES CO. MARYLAND | | | | | | | |
| 29a. CERTIFIER (Print name) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 30. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i> 30c. LICENSE NUMBER O.C.M.E. 30d. DATE SIGNED (Month, Day, Year) JUNE 22, 1995 | | | | | | | | | | | |
| 31. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) J. LARON LOCKE M.D. 111 Penn Street, Baltimore, Maryland 21201 | | | | | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JUN 26 1995 | | 32. REGISTRAR'S SIGNATURE <i>[Signature]</i> | | | | | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 21946

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) WILLY M. GOEBEL | | | | 2. DATE OF DEATH MONTH DAY YEAR June 30, 1995 | | 3. TIME OF DEATH 6:45 P M | |
| 4. SOCIAL SECURITY NUMBER 341-01-9508 | | 5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 98 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) Oct. 3, 1896 | |
| 8. BIRTHPLACE (State or Foreign Country) Germany | | | | 9a. FACILITY NAME (If not institution, give street and number) Washington Adventist Hospital | | 9b. CITY, TOWN OR LOCATION OF DEATH Takoma Park | |
| 9c. COUNTY OF DEATH Montgomery | | | | 10a. STATE Maryland | | 10b. COUNTY Prince George's | |
| 10c. CITY, TOWN OR LOCATION Hyattsville | | | | 10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 10e. STREET AND NUMBER 7213 Windsor Lane | |
| 10f. ZIP CODE 20782 | | | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | | 11. MARITAL STATUS 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) Guard | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Guard | | 16b. KIND OF BUSINESS/INDUSTRY Federal Government | |
| 17. FATHER'S NAME (First, Middle, Last) Unknown | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Unknown | | | |
| 19a. INFORMANT'S NAME (Type/Print) William J. Martens | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7213 Windsor Lane, Hyattsville, Maryland 20782 | | | |
| 20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Metropolitan Crematory 7/2/95 | | 20c. LOCATION — City or Town, State Alexandria, Virginia | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Charles F. Bell | | | | 22. NAME AND ADDRESS OF FACILITY Francis Gasch's Sons Funeral Home, P.A. 4739 Baltimore Ave., Hyattsville, MD 20781 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Pneumonia DUE TO (OR AS A CONSEQUENCE OF): Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ① Coronary Heart Disease ② Previous Stroke ③ Hypertension ④ Cancer Prostate DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | |
| 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | 28d. DESCRIBE HOW INJURY OCCURRED | | | |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER Mohammed A. Mannan MD | | | | 29c. LICENSE NUMBER D 24593 | | 29d. DATE SIGNED (Month, Day, Year) 07/01/95 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) MOHAMMED A. MANNAN MD, 3715-14TH AVE SE, MOUNT RAINIER, MD 20712 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JUL 06 1995 | | | | 32. REGISTRAR'S SIGNATURE John Andrew Randall | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 21947

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | |
|--|--|--|--|---|--|--|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) <i>John Goldberg</i> | | | | 2. DATE OF DEATH MONTH DAY YEAR <i>July 01 1995</i> | | | | 3. TIME OF DEATH <i>7:00 P.M.</i> | |
| 4. SOCIAL SECURITY NUMBER <i>216-40-6933</i> | | 5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) <i>53</i> YRS. | | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS. HOURS MIN. | |
| 7. DATE OF BIRTH (Month, Day, Year) <i>Aug. 19, 1941</i> | | | | 8. BIRTHPLACE (State or Foreign Country) <i>Washington, DC</i> | | | | | |
| 9a. FACILITY NAME (If not institution, give street and number) <i>Suburban Hospital</i> | | | | 9b. CITY, TOWN OR LOCATION OF DEATH <i>Bethesda</i> | | | | 9c. COUNTY OF DEATH <i>Montgomery</i> | |
| 10a. STATE <i>Maryland</i> | | | | 10b. COUNTY <i>Prince George's</i> | | 10c. CITY, TOWN OR LOCATION <i>College Park</i> | | | |
| 10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | | | | | | | | |
| 10e. STREET AND NUMBER <i>8808 34th Avenue</i> | | | | 10f. ZIP CODE <i>20740</i> | | | | 10g. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i> | |
| 11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES <i>Vietnam</i> | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: <i>White</i> | | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <i>9</i> College (1-4 or 5+) <i>College</i> | | 15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <i>Letter Carrier</i> | | 15b. KIND OF BUSINESS/INDUSTRY <i>U.S. Postal Service</i> | | | | | |
| 17. FATHER'S NAME (First, Middle, Last) <i>Frank Goldberg</i> | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) <i>Ary Elizabeth DeWalt</i> | | | | | |
| 19a. INFORMANT'S NAME (Type/Print) <i>Brenda J. Goldberg</i> | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>8808 34th Avenue, College Park, Maryland 20740</i> | | | | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <i>MD State Veterans Cem. 7/06/95</i> | | DATE <i>7/06/95</i> | | 20c. LOCATION — City or Town, State <i>Cheltenham, Maryland</i> | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Charles F. Bell</i> | | | | 22. NAME AND ADDRESS OF FACILITY <i>Francis Gasch's Sons Funeral Home, PA. 4739 Baltimore Ave., Hyattsville, MD 20781</i> | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Brain Death, Cerebral Edema</i> Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST <i>Intracranial Hemorrhage, Cerebral Edema Unknown Cause</i> <i>Atherosclerotic Heart Disease, Acute Myocardial Infarction</i> | | | | | | | | Approximate interval between Onset and Death <i>5-7 hrs.</i> <i>7-8 hrs.</i> <i>5-10 yrs.</i> | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | |
| 27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY <i>M</i> | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED | |
| | | 28e. PLACE OF INJURY — At home, farm, street, tectory, office building, etc. (Specify) | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. SIGNATURE AND TITLE OF CERTIFIER <i>Pradeep Srivastava</i> | | | | 29c. LICENSE NUMBER <i>D 33483</i> | | 29d. DATE SIGNED (Month, Day, Year) <i>7/9/95</i> | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>PRADEEP SRIVASTAVA, MD 9801 Greenbelt Road # 212, Lanham MD 20706</i> | | | | | | | | | |
| 31. DATE FILED (Month, Day, Year) <i>JUL 08 1995</i> | | 32. REGISTRAR'S SIGNATURE <i>Julia Bruckner-Randall</i> | | | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

114A

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 21948

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|--|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) EDNA GILMORE | | | | 2. DATE OF DEATH MONTH <u>July</u> DAY <u>1</u> YEAR <u>1995</u> | | 3. TIME OF DEATH <u>09:15 A</u> M | |
| 4. SOCIAL SECURITY NUMBER 414-70-1296 | | 5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 65 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) AUG. 9, 1929 | |
| 9a. FACILITY NAME (If not institution, give street and number) 10513 STORCH DRIVE | | | | 9b. CITY, TOWN OR LOCATION OF DEATH LANHAM | | 9c. COUNTY OF DEATH PRINCE GEORGE'S | |
| 10a. STATE MARYLAND | | | | 10b. COUNTY PRINCE GEORGE'S | | 10c. CITY, TOWN OR LOCATION LANHAM | |
| 10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | | | 10e. STREET AND NUMBER 10513 STORCH DRIVE | | 10f. ZIP CODE 20706 | |
| 10g. CITIZEN OF WHAT COUNTRY? USA | | | | 11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | |
| 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | | | 14. RACE — American Indian, Black, White, etc. Specify: BLACK | | 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12th College (1-4 or 5+) NURSING AID | |
| 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) PVT. | | | | 16b. KIND OF BUSINESS/INDUSTRY PVT. | | 17. FATHER'S NAME (First, Middle, Last) WILLIAM BLAKENEY | |
| 18. MOTHER'S NAME (First, Middle, Maiden Surname) AVIE FUNDERBURK | | | | 19a. INFORMANT'S NAME (Type/Print) MELVIN GILMORE/SON | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10513 STORCH DRIVE LANHAM, MARYLAND 20706 | |
| 20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input checked="" type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) FAUNDRY HILL CEMETERY 7-7-95 | | 20c. LOCATION — City or Town, State CHERAW, SC | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Quawana L. Braxton</i> | | | | 22. NAME AND ADDRESS OF FACILITY J. B. JENKINS FUNERAL HOME 7474 LANDOVER RD. LANDOVER, MD 20785 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Sepsis DUE TO (OR AS A CONSEQUENCE OF): a. Dehydration DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Status Epilepticus | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 28d. DESCRIBE NOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | 28g. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER <i>Jenny Y. May MD</i> | | | | 29c. LICENSE NUMBER D43260 | | 29d. DATE SIGNED (Month, Day, Year) July 3rd 1995 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 14333 Laurel Bowie Rd. #307 Laurel, MD 20708 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JUL 05 1995 | | | | 32. REGISTRAR'S SIGNATURE <i>Julia A. Woodard-Randall</i> | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 21949

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|---|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) DAISY VERONICA GARNER | | | | 2. DATE OF DEATH MONTH 7 / DAY 05 / YEAR 1995 | | 3. TIME OF DEATH 9:50AM | |
| 4. SOCIAL SECURITY NUMBER 578 46 2436 | | 5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 93 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) Oct. 27, 1901 | |
| 9a. FACILITY NAME (If not institution, give street and number) Villa Rosa Nursing Home | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Mitchellville | | 9c. COUNTY OF DEATH Prince George's | |
| 10a. STATE Maryland | | 10b. COUNTY Prince George's | | 10c. CITY, TOWN OR LOCATION Fort Washington | | 10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | |
| 10e. STREET AND NUMBER 718 Gleneagles Drive | | | | 10f. ZIP CODE 20744 | | 10g. CITIZEN OF WHAT COUNTRY? United States | |
| 11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES No | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: No | | 14. RACE — American Indian, Black, White, etc. Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 10 College (1-4 or 5+) | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Homemaker | | 16b. KIND OF BUSINESS/INDUSTRY Own Home | | | |
| 17. FATHER'S NAME (First, Middle, Last) James Irving Parker | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Lillian Josephine Garner | | | |
| 19a. INFORMANT'S NAME (Type/Print) Mr. Bill Garner | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 718 Gleneagles Drive Fort Washington Md. 20744 | | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematorium, or other place) Cedar Hill Cemetery 7/8/95 | | 20c. LOCATION — City or Town, State Suitland Maryland | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Robert E. Evans, Pres | | | | 22. NAME AND ADDRESS OF FACILITY Robert E. Evans Funeral Home, P.A. 16000 Annapolis Rd. Bowie Md. 20715 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Coronary Heart Failure Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. Coronary Heart Failure DUE TO (OR AS A CONSEQUENCE OF): b. Myocardial Infarction DUE TO (OR AS A CONSEQUENCE OF): c. Sepsis DUE TO (OR AS A CONSEQUENCE OF): d. | | | | | | | Approximate Interval Between Onset and Death |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |
| 27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| | | 28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28e. DESCRIBE HOW INJURY OCCURRED | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER [Signature] | | | | 29c. LICENSE NUMBER D14156 | | 29d. DATE SIGNED (Month, Day, Year) 7-5-95 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Gree D. Montague, MD 1300 Mercantile Lane - Landover | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JUL 08 1995 | | | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 21950

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) GERALDINE M. GROVE | | | | 2. DATE OF DEATH MONTH JULY DAY 4 YEAR 1995 | | 3. TIME OF DEATH 1:18 PM | |
| 4. SOCIAL SECURITY NUMBER 194-14-0882 | | 5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 72 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) June 8, 1923 | |
| 9a. FACILITY NAME (If not institution, give street and number) 2517 Senator Avenue | | | | 9b. CITY, TOWN OR LOCATION OF DEATH District Heights | | 9c. COUNTY OF DEATH Prince George's | |
| RESIDENCE OF DECEDENT | | | | | | | |
| 10a. STATE Maryland | | 10b. COUNTY Prince George's | | 10c. CITY, TOWN OR LOCATION District Heights | | 10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 10e. STREET AND NUMBER 2515 Senator Avenue | | | | 10f. ZIP CODE 20747 | | 10g. CITIZEN OF WHAT COUNTRY? U. S. A. | |
| 11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 2 College (1-4 or 5+) 2 | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Loan Specialist | | 16b. KIND OF BUSINESS/INDUSTRY Dept. of Agriculture | | | |
| 17. FATHER'S NAME (First, Middle, Last) Daniel Yoho | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Mable Grove | | | |
| 19a. INFORMANT'S NAME (Type/Print) Earl S. Grove | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2517 Senator Ave., District Heights, Md 20747 | | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) July 7, 1995 Maryland Veterans Cem. | | 20c. LOCATION — City or Town, State Cheltenham, Maryland | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | | | | 22. NAME AND ADDRESS OF FACILITY Lee Funeral Home, Inc. 6633 Old Alex. Ferry Rd., Clinton, Md. | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | | a. Carcinoma of the Lung DUE TO (OR AS A CONSEQUENCE OF): | | | | Approximate Interval Between Onset and Death 1 month | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | b. Respiratory arrest DUE TO (OR AS A CONSEQUENCE OF): | | | | 1 day | |
| | | c. Acute respiratory distress syndrome DUE TO (OR AS A CONSEQUENCE OF): | | | | 1 week | |
| | | d. | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Aspiration pneumonia Heart failure Hypertension (Rt leg) | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| | | 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER | | | | 29c. LICENSE NUMBER 020827 | | 29d. DATE SIGNED (Month, Day, Year) 7/5/95 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Glenn R. Jaucian M.D. 9450 Penn. Aven #18 Upper Marlboro Md 20772-3671 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JUL 6 1995 | | | | 32. REGISTRAR'S SIGNATURE | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

July 7, 1971
Maryland Veterans Cem

95 21951

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|---|--|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last) <i>Eugenia M Guerra</i> | | | | 2. DATE OF DEATH MONTH DAY YEAR <i>July 4, 1995</i> | | 3. TIME OF DEATH HOURS MINUTES AM/PM <i>9:30 P M</i> | |
| 4. SOCIAL SECURITY NUMBER <i>218-74-8422</i> | | 5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) <i>76</i> YRS. | | 7. DATE OF BIRTH (Month, Day, Year) <i>November 16, 1918</i> | |
| 9a. FACILITY NAME (If not institution, give street and number) <i>7667 Maple Avenue, #505</i> | | | | 9b. CITY, TOWN OR LOCATION OF DEATH <i>Takoma Park</i> | | 9c. COUNTY OF DEATH <i>Montgomery</i> | |
| RESIDENCE OF DECEDENT | | | | | | | |
| 10a. STATE <i>Maryland</i> | | 10b. COUNTY <i>Montgomery</i> | | 10c. CITY, TOWN OR LOCATION <i>Takoma Park</i> | | 10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | |
| 10e. STREET AND NUMBER <i>7667 Maple Avenue, #505</i> | | | | 10f. ZIP CODE <i>20912</i> | | 10g. CITIZEN OF WHAT COUNTRY? <i>Guatemala</i> | |
| 11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: <i>White</i> | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <i>12</i> College (1-4 or 5+) <i></i> | | 15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <i>Homemaker</i> | | 15b. KIND OF BUSINESS/INDUSTRY <i>Own Home</i> | | | |
| 17. FATHER'S NAME (First, Middle, Last) <i>Alberto Monrroy</i> | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) <i>Saturnina Guerra</i> | | | |
| 19a. INFORMANT'S NAME (Type/Print) <i>Yolanda Reyes</i> | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>4406 Braeside Court, Lanham, MD 20706</i> | | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <i>Maryland National Memorial Park 7/7/95</i> | | 20c. LOCATION — City or Town, State <i>Laurel, MD</i> | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Richard D. Smith</i> | | | | 22. NAME AND ADDRESS OF FACILITY <i>Rendon/Hale Funeral Home 9013 Annapolis Road, Lanham, MD 20706</i> | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Chronic Renal Failure</i> DUE TO (OR AS A CONSEQUENCE OF): <i>Diabetic Nephropathy</i> DUE TO (OR AS A CONSEQUENCE OF): <i>Insulin Dependent Diabetes Mellitus</i> DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | | Approximate Interval Between Onset and Death <i>Yrs</i> <i>Yrs</i> <i>35 yrs</i> |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Diabetic heart disease; retinopathy and neuropathy</i> <i>ASHD + LBBB + CAD</i> | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY <i>M</i> | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| 29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER <i>Bernadette Soong, MD</i> | | | | 29c. LICENSE NUMBER <i>D13550</i> | | 29d. DATE SIGNED (Month, Day, Year) <i>7/5/95</i> | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>Bernadette Soong, MD, 1106 Spring Street #2, Silver Spring MD 20910</i> | | | | | | | |
| 31. DATE FILED (Month, Day, Year) <i>JUL 07 1995</i> | | | | 32. REGISTRAR'S SIGNATURE <i>John D. ...</i> | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

P.O. BOX 68760

DIVISION OF VITAL RECORDS

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 21952

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|---|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) ROBERT Arthur HOHEISEL | | | | 2. DATE OF DEATH MONTH JULY DAY 3 YEAR 95 | | 3. TIME OF DEATH 21:57 M | |
| 4. SOCIAL SECURITY NUMBER 536-14-9124 | | 5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 69 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) Oct. 3, 1925 | |
| 8. BIRTHPLACE (State or Foreign Country) Illinois | | | | 9a. FACILITY NAME (If not institution, give street and number) Suburban Hospital | | 9b. CITY, TOWN OR LOCATION OF DEATH Bethesda | |
| 9c. COUNTY OF DEATH Montgomery | | | | 10a. STATE Maryland | | 10b. COUNTY Montgomery | |
| 10c. CITY, TOWN OR LOCATION Kensington | | | | 10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 10e. STREET AND NUMBER 10114 Crestwood Road | |
| 10f. ZIP CODE 20895 | | | | 10g. CITIZEN OF WHAT COUNTRY? United States | | | |
| 11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES World War II | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 1 College (1-4 or 5+) 1 | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Food Service & Equipment Director | | 16b. KIND OF BUSINESS/INDUSTRY Food | | | |
| 17. FATHER'S NAME (First, Middle, Last) Richard Frank Hoheisel | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Adele Inez Callender | | | |
| 19a. INFORMANT'S NAME (Type/Print) Helen N. Hoheisel | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10114 Crestwood Road, Kensington, Maryland 20895 | | | |
| 20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) July 5, 1995 Montgomery Crematorium, Inc. | | 20c. LOCATION — City or Town, State Bethesda, Maryland | | 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Michael P. Kutta M00348 | |
| 22. NAME AND ADDRESS OF FACILITY Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc., 7557 Wisconsin Avenue, Bethesda, MD 20814 | | 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. PULMONARY EMBOLISM DUE TO (OR AS A CONSEQUENCE OF): b. MYOCARDIAL INFARCTION DUE TO (OR AS A CONSEQUENCE OF): c. ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE DUE TO (OR AS A CONSEQUENCE OF): d. Approximate Interval Between Onset and Death ACUTE 1 DAY INDEX | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. CARCINOMA LUNG | | | | | | 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | | | DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/> | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29a. SIGNATURE AND TITLE OF CERTIFIER Francis C. Mayle | | | | 29c. LICENSE NUMBER D07099 | | 29d. DATE SIGNED (Month, Day, Year) JULY 4 95 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 29) (Type, Print) FRANCIS C. MAYLE 10215 FERNWOOD R. BETHESDA MD 20817 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JUL 07 1995 | | | | 32. REGISTRAR'S SIGNATURE John D. ... | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.



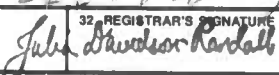
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

12+1

95 21953

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|--|--|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last) John Rodman Harrison | | | | 2. DATE OF DEATH MONTH DAY YEAR June 27 1995 | | 3. TIME OF DEATH 7:30 A M | |
| 4. SOCIAL SECURITY NUMBER 218-07-8758 | | 5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 78 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) May 23, 1917 | |
| 8. BIRTHPLACE (State or Foreign Country) Maryland | | 9a. FACILITY NAME (If not institution, give street and number) 3907 Stocong Drive | | 9b. CITY, TOWN OR LOCATION OF DEATH Beltsville | | 9c. COUNTY OF DEATH Prince Georges | |
| 10a. STATE Maryland | | | | 10b. COUNTY Prince Georges | | 10c. CITY, TOWN OR LOCATION Beltsville | |
| 10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | 10e. STREET AND NUMBER 3907 Stocong Drive | | 10f. ZIP CODE 20705 | |
| 10g. CITIZEN OF WHAT COUNTRY? USA | | 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES WW II | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | |
| 14. RACE — American Indian, Black, White, etc. Specify: White | | 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 1 | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Supervisor | | 16b. KIND OF BUSINESS/INDUSTRY Washington Gas Company | |
| 17. FATHER'S NAME (First, Middle, Last) John Kyle Harrison | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Wilma Cox | | | |
| 19a. INFORMANT'S NAME (Type/Print) Ruth Harrison | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3907 Stocong Drive, Beltsville, Maryland 20705 | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Fort Lincoln Cemetery | | DATE 6/30 | | 20c. LOCATION — City or Town, State Brentwood, Maryland | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE  | | | | 22. NAME AND ADDRESS OF FACILITY Hines-Rinaldi Funeral Home 11800 New Hampshire Avenue Silver Spring, Maryland 20904 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <u>Chronic renal Failure</u> DUE TO (OR AS A CONSEQUENCE OF): b. <u>Hypertensive Nephrosclerosis</u> DUE TO (OR AS A CONSEQUENCE OF): c. _____ DUE TO (OR AS A CONSEQUENCE OF): d. _____ Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | | Approximate Interval Between Onset and Death |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>old myocardial infarction</u> <u>Anemia</u> | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER  | | | | 29c. LICENSE NUMBER D26707 | | 29d. DATE SIGNED (Month, Day, Year) 6-29-95 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) TUNG PI LEE, MD 700 Buckingham Dr. Silver Spring MD | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JUL 07 1995 | | 32. REGISTRAR'S SIGNATURE  | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

68760

15

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

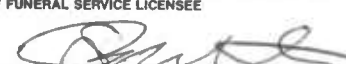
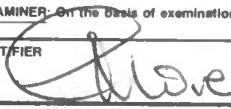

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 21954

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) Equilla Haynes | | | | 2. DATE OF DEATH MONTH June DAY 19 YEAR 1995 | | 3. TIME OF DEATH 10:30 P M | |
| 4. SOCIAL SECURITY NUMBER 140-26-1813 | | 5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (in yrs. last birthday) 76 YRS. | | 7. DATE OF BIRTH MONTH April DAY 12 YEAR 1919 | |
| 8. BIRTHPLACE (State or Foreign Country) Florida | | | | 9a. FACILITY NAME (If not institution, give street and number) Collingswood Nursing Home | | 9b. CITY, TOWN OR LOCATION OF DEATH Rockville, Maryland | |
| 9c. COUNTY OF DEATH Montgomery | | | | 10a. STATE D.C. | | | |
| 10b. COUNTY District of Columbia | | | | 10c. CITY, TOWN OR LOCATION Washington, D.C. | | | |
| 10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | 10e. STREET AND NUMBER 3400 22nd Street, N.E. | | | |
| 10f. ZIP CODE 20018 | | | | 10g. CITIZEN OF WHAT COUNTRY? USA | | | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: Black | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 9th College (1-4 or 5+) | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Housewife | | 16b. KIND OF BUSINESS/INDUSTRY | |
| 17. FATHER'S NAME (First, Middle, Last) Lennard Haynes | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Reacie Calender | | | |
| 19a. INFORMANT'S NAME (First, Middle, Last) Voneava Wilson | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3400 22nd Street, N.E., Washington, D.C. 20018 | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Harmony Memorial Park | | 20c. LOCATION — City or Town, State 6/26/95 Landover, Md | | 20d. DATE | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE  | | | | 22. NAME AND ADDRESS OF FACILITY Sam Butler Funeral Service 716 Kennedy St, N.W. Washington, D.C. 20011 | | | |
| 23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → Cerebrovascular accident | | | | | | | |
| Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | | |
| a. DUE TO (OR AS A CONSEQUENCE OF): Alzheimers disease | | | | | | | |
| b. DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| c. DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| d. DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | | | | |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | | | | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 6 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | 29a. CERTIFIER (Check only one) 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER  | | | | 29c. LICENSE NUMBER D20065 | | 29d. DATE SIGNED (Month, Day, Year) 6/22/95 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JUN 26 1995 | | | | 32. REGISTRAR'S SIGNATURE  | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 21955

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) Norma E. Hamilton | | | | 2. DATE OF DEATH MONTH June DAY 23 YEAR 1995 | | 3. TIME OF DEATH 3:31 A | |
| 4. SOCIAL SECURITY NUMBER 579-76-3242 | | 5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 58 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) Oct. 10, 1936 | |
| 8. BIRTHPLACE (State or Foreign Country) North Carolina | | | | 9a. FACILITY NAME (If not institution, give street and number) 3115 Queens Chapel Road # 101 | | 9b. CITY, TOWN OR LOCATION OF DEATH Mt. Rainier | |
| 9c. COUNTY OF DEATH Prince George's | | | | 10a. STATE Maryland | | 10b. COUNTY Prince George's | |
| 10c. CITY, TOWN OR LOCATION Mt. Rainier | | | | 10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 10e. STREET AND NUMBER 3115 Queens Chapel Road # 101 | |
| 10f. ZIP CODE 20719 | | | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | | 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced | |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 10 College (1-4 or 5+) College | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Homemaker | | 16b. KIND OF BUSINESS/INDUSTRY Own Home | |
| 17. FATHER'S NAME (First, Middle, Last) Azra Hamilton, Sr. | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Sallie Elizabeth Hudson | | | |
| 19a. INFORMANT'S NAME (Type/Print) Azra Hamilton, Jr. | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3115 Queens Chapel Road #101, Mt. Rainier, MD 20719 | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Gate of Heaven Cemetery 6/27/95 | | 20c. LOCATION — City or Town, State Silver Spring, Maryland | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE W.B. Geiser | | | | 22. NAME AND ADDRESS OF FACILITY Francis Gasch's Sons Funeral Home, P.A. 4739 Baltimore Ave., Hyattsville, MD 20781 | | | |
| 23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Arteriosclerotic cardiovascular disease DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | 29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER Augusto P. Rodriguez MD | | | | 29c. LICENSE NUMBER 221230 | | 29d. DATE SIGNED (Month, Day, Year) June 23, 1995 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Augusto P. Rodriguez MD, 5007 Rayburn Ct. Gp 2 Sp. MD 20745 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JUN 26 1995 | | | | 32. REGISTRAR'S SIGNATURE John A. Hudson | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 21956

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|---|--|--|---|
| 1. DECEDENT'S NAME (First, Middle, Last) Brooke E. Hartman | | | | 2. DATE OF DEATH MONTH DAY YEAR July 1, 1995 | | 3. TIME OF DEATH 7:00A M | |
| 4. SOCIAL SECURITY NUMBER 246-10-4999 | | 5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 80 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) Sept. 6, 1914 | |
| 8. BIRTHPLACE (State or Foreign Country) North Carolina | | | | | | | |
| 9a. FACILITY NAME (If not institution, give street and number) 9501 Tiberias Drive | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Upper Marlboro | | 9c. COUNTY OF DEATH Prince George's | |
| 10a. STATE Maryland | | | | 10b. COUNTY Prince George's | | 10c. CITY, TOWN OR LOCATION Upper Marlboro | |
| 10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | | | | |
| 10e. STREET AND NUMBER 9501 Tiberias Drive | | | | 10f. ZIP CODE 20772 | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (14 or 5 +) 3 | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Administrative Clerk | | 16b. KIND OF BUSINESS/INDUSTRY Hecht Co. Department Store | | | |
| 17. FATHER'S NAME (First, Middle, Last) Joseph J. Edwards | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Sally Umberger | | | |
| 19a. INFORMANT'S NAME (Type/Print) Heidi L. King | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9501 Tiberias Dr. Upper Marlboro, Md. 20772 | | | |
| 20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Metropolitan Crematory 7/3/95 | | 20c. LOCATION — City or Town, State Alexandria, Virginia | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>George P. Kalas</i> | | | | 22. NAME AND ADDRESS OF FACILITY George P. Kalas Funeral Home 6160 Oxon Hill Rd. Oxon Hill, Md. 20745 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Metastatic Carcinoma - unknown Primary DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. | | | | | | | Approximate Interval Between Onset and Death 9 months |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | | | | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 6 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 6 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER <i>Charles A. Umosella</i> | | | | 29c. LICENSE NUMBER D30484 | | 29d. DATE SIGNED (Month, Day, Year) 7/3/95 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Charles Umosella, M.D. 4333 Old Branch Ave. Marlow Hts, MD 20746 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JUL 06 1995 | | 32. REGISTRAR'S SIGNATURE <i>John Andrew Raskell</i> | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

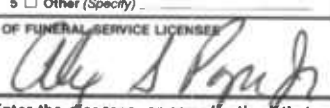

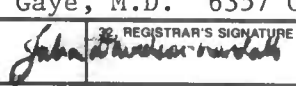
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 21957

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|---|--|---|--|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last) LOU-FANNIE HARRIS | | | | 2. DATE OF DEATH MONTH JUNE DAY 28 YEAR 1995 | | 3. TIME OF DEATH 5:59 A. M. | |
| 4. SOCIAL SECURITY NUMBER 579-32-4259 | | 5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 81 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) JUN 21, 1914 | |
| 9a. FACILITY NAME (If not institution, give street and number) 1126 Kayak Avenue | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Capitol Heights | | 9c. COUNTY OF DEATH Prince Georges | |
| 10a. STATE Maryland | | | | 10b. COUNTY Prince Georges | | 10c. CITY, TOWN OR LOCATION Capitol Heights | |
| 10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | | | 10e. STREET AND NUMBER 1126 Kayak Avenue | | | |
| 10f. ZIP CODE 20743 | | | | 10g. CITIZEN OF WHAT COUNTRY? United States | | | |
| 11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: BLACK | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 3 College (1-4 or 5+) | | 18a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) HOUSEWIFE | | 18b. KIND OF BUSINESS/INDUSTRY PRIVATE HOME | | | |
| 17. FATHER'S NAME (First, Middle, Last) ALFRED JOHNSON TRAYNHAM | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) ANNIE SINGLETON | | | |
| 19a. INFORMANT'S NAME (Type/Print) BELINDA DIGG-HALL | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1126 KAYAK AVENUE, CAPITOL HTS., MD. 20743 | | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) HARMONY MEMORIAL PARK | | DATE 7/5 | | 20c. LOCATION — City or Town, State LANDOVER, M, ARYLAND | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE  M859 | | | | 22. NAME AND ADDRESS OF FACILITY ALEXANDER S. POPE FUNERAL HOMES 5538 MARLBORO PIKE, FORESTVILLE, MD 20747 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → ADENO CARCINOMA OF STOMACH DUE TO (OR AS A CONSEQUENCE OF): Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. | | | | | | | Approximate Interval Between Onset and Death 2 Months |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28d. DESCRIBE HOW INJURY OCCURRED | | | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| 29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER  MD | | | | 29c. LICENSE NUMBER D 33050 | | 29d. DATE SIGNED (Month, Day, Year) June 28, 1995 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Dr. David E. Gaye, M.D. 6357 Oxon Hill Road, Oxon Hill, Md. | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JUL 08 1995 | | | | 32. REGISTRAR'S SIGNATURE  | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 21958

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | |
|---|--|--|--|--|---|
| 1. DECEDENT'S NAME (First, Middle, Last) <i>Elijah Hamilton</i> | | 2. DATE OF DEATH MONTH DAY YEAR <i>June 28, 1995</i> | | 3. TIME OF DEATH <i>6:12 P</i> M | |
| 4. SOCIAL SECURITY NUMBER 213-07-8249 | | 5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 79 YRS. | |
| 7. DATE OF BIRTH (Month, Day, Year) February 4, 1916 | | 8. BIRTHPLACE (State or Foreign Country) South Carolina | | | |
| 9a. FACILITY NAME (If not institution, give street and number) Prince George's Hospital Center | | 9b. CITY, TOWN OR LOCATION OF DEATH Cheverly | | 9c. COUNTY OF DEATH Prince George's | |
| 10a. STATE Maryland | | 10b. COUNTY Prince George's | | 10c. CITY, TOWN OR LOCATION Landover | |
| 10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | 10e. STREET AND NUMBER 7725 Oxman Road | | 10f. ZIP CODE 20785 | |
| 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | | 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | |
| 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: Black | | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 10 College (1-4 or 5+) 10 | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Construction | | 16b. KIND OF BUSINESS/INDUSTRY Self Employed | |
| 17. FATHER'S NAME (First, Middle, Last) Edward Hamilton | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Florence Shepherd | | | |
| 19a. INFORMANT'S NAME (Type/Print) Joyce Fletcher | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7725 Oxman Road, Landover, Maryland 20785 | | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Jenolan Baptist Church Cemetery 7/5 | | 20c. LOCATION — City or Town, State Jamestown, South Carolina | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Shawana D. Braxton</i> | | 22. NAME AND ADDRESS OF FACILITY J.B. Jenkins Funeral Home 7474 Landover Road, Landover, MD 20785 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Hypertensive atherosclerotic cerebro-vascular disease</i> DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. | | | | | Approximate Interval Between Onset and Death |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | |
| 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | 29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER <i>Augusto P. Rodriguez MD</i> | | 29c. LICENSE NUMBER A21230 | | 29d. DATE SIGNED (Month, Day, Year) <i>June 30, 1995</i> | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>Augusto P. Rodriguez MD, 5009 Layburn Ct. N. Sp. Md 20748</i> | | | | | |
| 31. DATE FILED (Month, Day, Year) JUL 03 1995 | | 32. REGISTRAR'S SIGNATURE <i>John Davidson-Randall</i> | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

2021
12/15/21
12/15/21

95 21959

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|---|--|--|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) Lucius S. Henderson | | | | 2. DATE OF DEATH MONTH DAY YEAR June 26, 1995 | | 3. TIME OF DEATH 6:00 A.M. | |
| 4. SOCIAL SECURITY NUMBER 577-12-1843 | | 5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 82 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) Dec 3, 1912 | |
| 8. BIRTHPLACE (State or Foreign Country) Wash., DC | | | | 9a. FACILITY NAME (If not institution, give street and number) Washington Adventist Hospital | | 9b. CITY, TOWN OR LOCATION OF DEATH Takoma Park | |
| 9c. COUNTY OF DEATH Montgomery | | | | 10a. STATE MD | | | |
| 10b. COUNTY Prince Georges | | 10c. CITY, TOWN OR LOCATION Hyattsville | | 10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | | |
| 10e. STREET AND NUMBER 5637 Sargent Road | | | | 10f. ZIP CODE 20782 | | 10g. CITIZEN OF WHAT COUNTRY? USA | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— if yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: Black | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 8th College (14 or 5+) _____ | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) US Postal Service | | 16b. KIND OF BUSINESS/INDUSTRY Federal Government | | | |
| 17. FATHER'S NAME (First, Middle, Last) Frederick Henderson | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Sarah | | | |
| 19a. INFORMANT'S NAME (Type/Print) Inez A. Henderson | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5637 Sargent Rd. Hyattsville, Md. 20782 | | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) CHELTENHAM VETERAN CEM 6/29/95 CHELTENHAM, MD. | | 20c. LOCATION — City or Town, State | | 20d. DATE | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | | | | 22. NAME AND ADDRESS OF FACILITY Johnson & Jenkins Funeral Home 716 Kennedy St., N.W., Wash., DC 20011 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | | a. Stage D-2 Prostate Cancer DUE TO (OR AS A CONSEQUENCE OF): | | | | Approximate interval Between Onset and Death 1 1/2 yrs | |
| Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | b. Metastatic Cancer of Bones DUE TO (OR AS A CONSEQUENCE OF): | | | | 1 1/2 yrs | |
| | | c. _____ DUE TO (OR AS A CONSEQUENCE OF): | | | | | |
| | | d. _____ DUE TO (OR AS A CONSEQUENCE OF): | | | | | |
| | | PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| | | 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. SIGNATURE AND TITLE OF CERTIFIER | | 29c. LICENSE NUMBER AY6209301 | | 29d. DATE SIGNED (Month, Day, Year) June 27, 1995 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Dal Yoo, M.D., 1160 Varnum St., N.E., Wash., D.C. 20017 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JUN 28 1995 | | | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

P.O. BOX 68760

4

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 21960

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|--|--|---|--|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last) JAMES A. HOPPS | | | | 2. DATE OF DEATH MONTH DAY YEAR June 25, 1995 | | 3. TIME OF DEATH 6:45 am M | |
| 4. SOCIAL SECURITY NUMBER 578-56-2368 | | 5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 53 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) May 12, 1942 | |
| 8. BIRTHPLACE (State or Foreign Country) Washington, DC | | | | 9a. FACILITY NAME (If not institution, give street and number) 7111 Walker Mill Road | | 9b. CITY, TOWN OR LOCATION OF DEATH District Heights, MD | |
| 9c. COUNTY OF DEATH Prince Georges | | | | 10a. STATE Maryland | | 10b. COUNTY Prince Georges | |
| 10c. CITY, TOWN OR LOCATION District Heights, MD | | | | 10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | 10e. STREET AND NUMBER 7111 Walker Mill Road | |
| 10f. ZIP CODE 20743 | | | | 10g. CITIZEN OF WHAT COUNTRY? USA | | | |
| 11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES 4/65 to Oct 68 | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: Black | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) _____ | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Federal Protective Officer | | 16b. KIND OF BUSINESS/INDUSTRY Federal Government | | | |
| 17. FATHER'S NAME (First, Middle, Last) William Hopps | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Irma Butler | | | |
| 19a. INFORMANT'S NAME (Type/Print) Lillie T. Hopps | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7111 Walker Mill Road, District Heights, MD | | | |
| 20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) _____ | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Metropolitan Crematory 6/29/95 | | 20c. LOCATION — City or Town, State Alexandria, VA | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Alexander S. Pope, Jr.</i> | | | | 22. NAME AND ADDRESS OF FACILITY Alexandria S. Pope Funeral Home 2617 Pennsylvania Ave SE Wash., D.C. 20020 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Metastatic Esophageal Carcinoma DUE TO (OR AS A CONSEQUENCE OF): a. _____ b. _____ c. _____ d. _____ Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | | Approximate Interval Between Onset and Death |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ADD, HYPERTENSION | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO | | | | | | | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) _____ | | | | | |
| 27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i> | | | | 29c. LICENSE NUMBER 17946 | | 29d. DATE SIGNED (Month, Day, Year) 6/26/95 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) ZAIL S. BERRY, M.D., M.P.H. 2150 Pennsylvania Ave., NW., Washington, D.C. 20037 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JUN 28 1995 | | | | 32. REGISTRAR'S SIGNATURE <i>[Signature]</i> | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

8

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician.

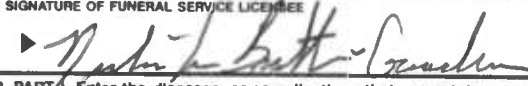

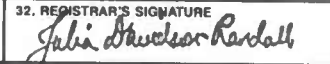
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 21961

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|---|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) Gertrude Tilley Hallila | | | | 2. DATE OF DEATH MONTH DAY YEAR June 30, 1995 | | 3. TIME OF DEATH 12:20 AM | |
| 4. SOCIAL SECURITY NUMBER 238-03-8142 | | 5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 77 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) Sept 27, 1917 | |
| 9a. FACILITY NAME (If not institution, give street and number) Malcolm Grow Medical Center | | | | 9b. CITY, TOWN OR LOCATION OF DEATH AAFB | | 9c. COUNTY OF DEATH Prince George's | |
| 10a. STATE Maryland | | | | 10b. COUNTY Prince George | | 10c. CITY, TOWN OR LOCATION Temple Hills | |
| 10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input type="checkbox"/> NO | | | | 10e. STREET AND NUMBER 3311 26th Ave | | | |
| 10f. ZIP CODE 20748 | | | | 10g. CITIZEN OF WHAT COUNTRY? United States | | | |
| 11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12th College (1-4 or 5+) 12th | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Foreign Funds Control | | 16b. KIND OF BUSINESS/INDUSTRY U.S. Treasury Dept | | | |
| 17. FATHER'S NAME (First, Middle, Last) William R. Tilley | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Beadie Gates | | | |
| 19a. INFORMANT'S NAME (Type/Print) Esko E. Hallila | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3311 26th Ave, Temple Hills, MD 20748-2809 | | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Cedar Hill Cemetery July 3, 1995 | | 20c. LOCATION — City or Town, State Suitland, Md | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE  | | | | 22. NAME AND ADDRESS OF FACILITY Lee Funeral Home, Inc 6633 Old Alexander Ferry Road, Clinton, MD | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | | a. cardiopulmonary failure and renal failure | | | | | |
| | | b. multiple organ failure | | | | | |
| | | c. systemic infection | | | | | |
| | | d. acute and chronic interstitial lung disease | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO N/A | | | | | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 28d. DESCRIBE NOW INJURY OCCURRED | | | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| 29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER  | | | | 29c. LICENSE NUMBER 17128 ALBANA | | 29d. DATE SIGNED (Month, Day, Year) 30 June '95 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) MICHAEL COGHAN, MAJ, USAF, MC | | | | 31. DATE FILED (Month, Day, Year) JUL 06 1995 | | | |
| 32. REGISTRAR'S SIGNATURE  | | | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 21962

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|---|--|---|--|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last) Taylor, James Herbert | | | | 2. DATE OF DEATH MONTH DAY YEAR July 3 1995 | | 3. TIME OF DEATH 1623 P M | |
| 4. SOCIAL SECURITY NUMBER 214-30-2216 | | 5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 60 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) August 17 1934 | |
| 9a. FACILITY NAME (If not institution, give street and number) Washington Adventist Hospital | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Takoma Park | | 9c. COUNTY OF DEATH MONTGOMERY | |
| RESIDENCE OF DECEDENT | | | | | | | |
| 10a. STATE Maryland | | 10b. COUNTY Prince George's | | 10c. CITY, TOWN OR LOCATION Mount Rainer | | 10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 10e. STREET AND NUMBER 4306 34th Street #4 | | | | 10f. ZIP CODE 20712 | | 10g. CITIZEN OF WHAT COUNTRY? USA | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES Korean | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) _____ | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Chief of Security | | 16b. KIND OF BUSINESS/INDUSTRY Security | | | |
| 17. FATHER'S NAME (First, Middle, Last) Oscar H. Taylor | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Sadie A. Vaughn Taylor | | | |
| 19a. INFORMANT'S NAME (Type/Print) Katrina M. McDonald | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 771 Willow Way Prince Frederick, MD 20678 | | | |
| 20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Metropolitan Crematory 7-6-95 | | 20c. LOCATION — City or Town, State Alexandria, VA | | 20d. DATE | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>John A. Eberwein</i> M00173 | | | | 22. NAME AND ADDRESS OF FACILITY J.H. Eberwein Mortuary 4433 White Pls La White Pls., MD 20695 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <u>COPD</u> DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. _____ DUE TO (OR AS A CONSEQUENCE OF): c. _____ DUE TO (OR AS A CONSEQUENCE OF): d. _____ | | | | | | | Approximate Interval Between Onset and Death 10 yrs |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| 28d. DESCRIBE NOW INJURY OCCURRED | | | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| 29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER <i>Jeffrey Kelman MD</i> | | | | 29c. LICENSE NUMBER D20391 | | 29d. DATE SIGNED (Month, Day, Year) July 4, 1995 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) JEFFREY KELMAN 6525 BELLEVIEW RD, HYATTSVILLE, MD 20782 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JUL 06 1995 | | | | 32. REGISTRAR'S SIGNATURE <i>John A. Eberwein</i> | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

P.O. BOX 68760

DIVISION OF VITAL RECORDS

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Hodges Jr, Harry

95 21963

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) HARRY Joseph HODGES, Jr | | | | 2. DATE OF DEATH MONTH JULY DAY 3 YEAR 1995 | | 3. TIME OF DEATH 11:00 A M | |
| 4. SOCIAL SECURITY NUMBER 578-12-3051 | | 5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 72 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) Oct 2, 1922 | |
| 8. BIRTHPLACE (State or Foreign Country) Washington DC | | | | 9a. FACILITY NAME (If not institution, give street and number) Southern Maryland Hospital | | 9b. CITY, TOWN OR LOCATION OF DEATH Clinton | |
| 9c. COUNTY OF DEATH Prince George's | | | | 10a. STATE Maryland | | 10b. COUNTY Prince George's | |
| 10c. CITY, TOWN OR LOCATION Camp Springs | | | | 10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input type="checkbox"/> NO | | 10e. STREET AND NUMBER 6309 Westridge Court | |
| 10f. ZIP CODE 20748 | | | | 10g. CITIZEN OF WHAT COUNTRY? United States | | 11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4 or 5+) <input type="checkbox"/> | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Civil Servant | | 16b. KIND OF BUSINESS/INDUSTRY US Navy Dept | |
| 17. FATHER'S NAME (First, Middle, Last) Harry Hodges Sr | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Florence Virginia Thomas | | | |
| 19a. INFORMANT'S NAME (Type/Print) Ester Hodges | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6309 Westridge Court Camp Springs, Md 20748 | | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematorium, or other place) Cedar Hill Cemetery 7-7-95 | | 20c. LOCATION — City or Town, State Suitland, Maryland | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Charles L. Belanger | | | | 22. NAME AND ADDRESS OF FACILITY Lee Funeral Home, Inc Old Alexander Ferry Rd, Clinton, MD | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Metastatic Abdominal Adenocarcinoma 4 yrs. Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. congestive heart failure, renal failure. | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO | | | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/> | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | |
| 27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide | | | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | |
| 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | 28d. DESCRIBE HOW INJURY OCCURRED | | | |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER Sam T. Tellawi | | | | 29c. LICENSE NUMBER D34274 | | 29d. DATE SIGNED (Month, Day, Year) 7.3.95 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) E. TELLAWI 7700 OLD BRANCH AVE, CLINTON MD 20735 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JUL 06 1995 | | | | 32. REGISTRAR'S SIGNATURE John A. Woodson-Randall | | | |

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

95 21964

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) Sara Spencer Hoskins | | | | 2. DATE OF DEATH MONTH DAY YEAR July 2 1995 | | 3. TIME OF DEATH 5:30 P M | |
| 4. SOCIAL SECURITY NUMBER 230-03-8969 | | 5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 73 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 7/7/1921 | |
| 8. BIRTHPLACE (State or Foreign Country) West Virginia | | | | 9a. FACILITY NAME (If not institution, give street and number) 704 Dayspring Drive | | 9b. CITY, TOWN OR LOCATION OF DEATH Odenton | |
| 9c. COUNTY OF DEATH Baltimore | | | | 10a. STATE MD | | 10b. COUNTY Carroll | |
| 10c. CITY, TOWN OR LOCATION Westminster | | | | 10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | 10e. STREET AND NUMBER 75 Liberty Street | |
| 10f. ZIP CODE 21157 | | | | 10g. CITIZEN OF WHAT COUNTRY? United States | | 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: white | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) ? College (1-4 or 5+) | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) clerk/secretary | | 16b. KIND OF BUSINESS/INDUSTRY hospital | |
| 17. FATHER'S NAME (First, Middle, Last) Herman Spencer | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Blanche S. | | | |
| 19a. INFORMANT'S NAME (Type/Print) Mary Hoskins | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 704 Dayspring Dr., Odenton, MD 21113 | | | |
| 20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Lorraine Park Cemetery 7/5/95 DATE | | 20c. LOCATION — City or Town, State Woodlawn, MD | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Katherine Pitts - Sweitzer | | | | 22. NAME AND ADDRESS OF FACILITY Pritts Funeral Home & Chapel 412 Washington Rd., Westminster, MD | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. METASTATIC BREAST CARCINOMA DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): Approximate interval Between Onset and Death 8 MONTHS | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide | | | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | |
| 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | 28d. DESCRIBE NOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER Victor M. Priego, M.D. | | | | 29c. LICENSE NUMBER D23308 | | 29d. DATE SIGNED (Month, Day, Year) 07/06/95 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) VICTOR M. PRIEGO, M.D. 11420 ROCKVILLE PIKE, ROCKVILLE, MD. 20852 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JUL 07 1995 | | | | 32. REGISTRAR'S SIGNATURE John Andrew Randall | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 21965

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) Andrew (nm) Hoffmann | | | | 2. DATE OF DEATH MONTH July DAY 5 YEAR 1995 | | 3. TIME OF DEATH 10:40 A^m | |
| 4. SOCIAL SECURITY NUMBER 213-03-9209 | | 5. SEX 1 <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 94 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) Aug. 29, 1900 | |
| 9a. FACILITY NAME (If not institution, give street and number) Harford Memorial Hospital | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Havre de Grace | | 9c. COUNTY OF DEATH Harford | |
| 10a. STATE Maryland | | | | 10b. COUNTY Harford | | 10c. CITY, TOWN OR LOCATION Joppa | |
| 10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | 10e. STREET AND NUMBER 1218 Old Mountain Rd. | | | |
| 10f. ZIP CODE 21085 | | | | 10g. CITIZEN OF WHAT COUNTRY? USA | | | |
| 11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 8 | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Butcher | | 16b. KIND OF BUSINESS/INDUSTRY Meat Packaging | | | |
| 17. FATHER'S NAME (First, Middle, Last) unknown | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) unknown | | | |
| 19a. INFORMANT'S NAME (Type/Print) Helen E. Hackett | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1700 Mountain Rd., Joppa, Md. 21085 | | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Bel Air Memorial Gardens | | 20c. LOCATION — City or Town, State 7-8-95 Bel Air, Maryland | | 20d. DATE | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Stephen A. Hughes | | | | 22. NAME AND ADDRESS OF FACILITY Howard K. McComas III Funeral Home, P.A. 1317 Cokesbury Rd., Abingdon, Md. 21009 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Congestive Heart Failure DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST b. _____ DUE TO (OR AS A CONSEQUENCE OF): c. _____ DUE TO (OR AS A CONSEQUENCE OF): d. _____ | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Hypertension ATHEROSCLEROTIC DISEASE | | | | | | | |
| 24. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DDA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER Harold S. Simon MD | | | | 29c. LICENSE NUMBER MD 412 | | 29d. DATE SIGNED (Month, Day, Year) 7/8/95 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) William 319 S. Union Ave Harford DE Green MD 21076 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JUL 06 1995 | | | | 32. REGISTRAR'S SIGNATURE John Anderson-Randall | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 21966

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|--|--|---|--|---|--|
| 1. DECEASED'S NAME (First, Middle, Last) Robert Page Jett | | | | 2. DATE OF DEATH MONTH 7 DAY 2 YEAR 95 | | 3. TIME OF DEATH 2:55 A M | |
| 4. SOCIAL SECURITY NUMBER 219-26-6818 | | 5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 57 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) March 25, 1938 | |
| 8. BIRTHPLACE (State or Foreign Country) Maryland | | | | 9a. FACILITY NAME (If not institution, give street and number) Anne Arundel Medical Centery | | 9b. CITY, TOWN OR LOCATION OF DEATH Annapolis | |
| 9c. COUNTY OF DEATH Anne Arundel | | | | 10a. STATE Maryland | | 10b. COUNTY Anne Arundel | |
| 10c. CITY, TOWN OR LOCATION Gambrills | | | | 10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 10e. STREET AND NUMBER 2004 Huntcliff Drive | |
| 10f. ZIP CODE 21054 | | | | 10g. CITIZEN OF WHAT COUNTRY? United States | | | |
| 11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEASED EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES No | | 13. WAS DECEASED OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: No | | 14. RACE — American Indian, Black, White, etc. Specify: White | |
| 15. DECEASED'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 2 College (1-4 or 5+) 2 | | 16a. DECEASED'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Marine Scientist | | 16b. KIND OF BUSINESS/INDUSTRY State of Maryland | | | |
| 17. FATHER'S NAME (First, Middle, Last) Page C. Jett | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Vashti Muinch | | | |
| 19a. INFORMANT'S NAME (Type/Print) Sandra I. Jett | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2004 Huntcliff Drive Gambrills Maryland 21054 | | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Lakemont Memorial Gardens 7/6/95 Davidsonville Md. | | 20c. LOCATION — City or Town, State | | 20d. DATE 7/6/95 | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Robert E. Evans Pres. | | | | 22. NAME AND ADDRESS OF FACILITY Robert E. Evans Funeral Home, P.A. 16000 Annapolis Rd. Bowie MD. 20715 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → metastatic Esophageal Carcinoma DUE TO (OR AS A CONSEQUENCE OF): Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. | | | | | | Approximate Interval Between Onset and Death 2 1/2 yrs | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/> | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER Wayne P. Baum MD | | | | 29c. LICENSE NUMBER D38563 | | 29d. DATE SIGNED (Month, Day, Year) 7/2/95 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Wayne P. Baum 134 Owensville Rd West River MD | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JUL 06 1995 | | | | 32. REGISTRAR'S SIGNATURE Johanna K. Randall | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95-3715-033

95-154

blh

Amended # 10b, P.G. 6, 7/3/95

95 21967

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|--|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) RODERICK EDWARD JOHNS | | | | 2. DATE OF DEATH MONTH DAY YEAR June 25 1995 | | 3. TIME OF DEATH 1055 AM | |
| 4. SOCIAL SECURITY NUMBER 579-88-7438 | | 5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 22 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 6-11-73 | |
| 8. BIRTHPLACE (State or Foreign Country) Washington DC | | | | 9a. FACILITY NAME (If not institution, give street and number) 1800 block Longford Drive | | 9b. CITY, TOWN OR LOCATION OF DEATH Chillum | |
| 9c. COUNTY OF DEATH Prince Georges | | | | 10a. STATE MD | | 10b. COUNTY Montgomery | |
| 10c. CITY, TOWN OR LOCATION Silver Spring | | | | 10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | 10e. STREET AND NUMBER 9316 Piney Branch Road | |
| 10f. ZIP CODE 20903 | | | | 10g. CITIZEN OF WHAT COUNTRY? USA | | 11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | | |
| 14. RACE — American Indian, Black, White, etc. Specify: Black | | | | 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 11th College (1-4 or 5+) Unemployed | | | |
| 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Unemployed | | | | 16b. KIND OF BUSINESS/INDUSTRY | | | |
| 17. FATHER'S NAME (First, Middle, Last) James L. Johns | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Vivian L. Crowder | | | |
| 19a. INFORMANT'S NAME (Type/Print) Vivian L. Price | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9316 Piney Branch Road Silver Spring, Md. 20903 | | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Lincoln Memorial Cemetery 7-3 | | | |
| 20c. LOCATION — City or Town, State Suitland, Md. | | | | 21. SIGNATURE OF FUNERAL SERVICE LICENSEE J. P. Marshall | | | |
| 22. NAME AND ADDRESS OF FACILITY Marshall's Funeral Home, Inc. 4217 9th Street, N. W. Washington, D. C. 20011 | | | | 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Gunshot Wound of Head DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. Gunshot Wound of Head DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | 24a. WAS AN AUTOPSY PERFORMED? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | | |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | | | DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) at scene | | | |
| 27. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | | | 28a. DATE OF INJURY (Month, Day, Year) 6/25/95 | | | |
| 28b. TIME OF INJURY 0825 AM | | | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | |
| 28d. DESCRIBE HOW INJURY OCCURRED subject shot | | | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) roadway | | | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) 1806 Longford Drive Prince Georges County, Maryland | | | | 29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER THEODORE McKINNEY | | | | 29c. LICENSE NUMBER O.C.M.E. | | | |
| 29d. DATE SIGNED (Month, Day, Year) June 26 1995 | | | | 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) THEODORE McKINNEY 111 Penn Street, Baltimore, Maryland 21201 | | | |
| 31. DATE FILED (Month, Day, Year) JUL 03 1995 | | | | 32. REGISTRAR'S SIGNATURE John A. ... | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

P.O. BOX 68760

DIVISION OF VITAL RECORDS

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 21968

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | | | |
|---|--|---|---|---|--|--|---|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) John Edward Jackson | | | | 2. DATE OF DEATH MONTH DAY YEAR June 27 1995 | | | | 3. TIME OF DEATH 10:00 P M | | | |
| 4. SOCIAL SECURITY NUMBER 577-34-6207 | | 5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | 6. AGE (In yrs. last birthday) 68 YRS. | 7. DATE OF BIRTH (Month, Day, Year) March 6, 1927 | | 8. BIRTHPLACE (State or Foreign Country) Wash., DC | | | | | |
| 9a. FACILITY NAME (If not Institution, give street and number) 1209 Kingstree Drive | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Mitchellville | | | 9c. COUNTY OF DEATH Prince Georges | | | | |
| RESIDENCE OF DECEDENT | | | | | | | | | | | |
| 10a. STATE Maryland | | 10b. COUNTY Prince Georges | | 10c. CITY, TOWN OR LOCATION Mitchellville | | | 10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | |
| 10e. STREET AND NUMBER 1209 Kingstree Drive | | | | 10f. ZIP CODE 20721 | | 10g. CITIZEN OF WHAT COUNTRY? USA | | | | | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES 10/50 to 8/52 | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | | 14. RACE — American Indian, Black, White, etc. Specify: Black | | | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (9-12) 10 College (1-4 or 5+) 10 | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Lab Technician | | | 16b. KIND OF BUSINESS/INDUSTRY NIH | | | | |
| 17. FATHER'S NAME (First, Middle, Last) John Edward Jackson, Sr. | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Lula Virginia Douglas | | | | | | | |
| 19a. INFORMANT'S NAME (Type/Print) A. Jackson | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1209 Kingstree Drive, Mitchellville, MD 20721 | | | | | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Ft. Lincoln Cemetery | | DATE | | 20c. LOCATION — City or Town, State Brentwood, MD | | | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE J. P. Marshall | | | | 22. NAME AND ADDRESS OF FACILITY Marshall's Funeral Home, Inc. 4217 9th St., N.W., Wash., DC 20011 | | | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Carcinoma of the Pancreas DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. | | | | | | | | Approximate interval Between Onset and Death | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED | | | |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| 29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER | | | | 29c. LICENSE NUMBER D19431 | | | 29d. DATE SIGNED (Month, Day, Year) 6/29/1995 | | | | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Frank M. Ryan, M.D. 6188 Oxon Hill Rd., #601, Oxon Hill, MD 20745 | | | | | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JUL 03 1995 | | | | 32. REGISTRAR'S SIGNATURE John Edward Jackson | | | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95-3793-510
blh

95 21969

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|---|--|---|--------------------------------|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) Harold E Kelly | | | | 2. DATE OF DEATH MONTH DAY YEAR June 29 1995 | | 3. TIME OF DEATH 0355 | |
| 4. SOCIAL SECURITY NUMBER | | 5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F | 6. AGE (In yrs. last birthday) 43 YRS. | IF UNDER 1 YEAR MONTHS DAYS | IF UNDER 24 HRS. HOURS MIN. | 7. DATE OF BIRTH (Month, Day, Year) Dec. 24, 1951 | |
| 8. BIRTHPLACE (State or Foreign Country) Maryland | | | | 9. COUNTY OF DEATH | | | |
| 9a. FACILITY NAME (If not institution, give street and number) 311 Cathedral Street | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Baltimore | | 9c. COUNTY OF DEATH | |
| 10a. STATE Maryland | | 10b. COUNTY | | 10c. CITY, TOWN OR LOCATION Baltimore | | 10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input type="checkbox"/> NO | |
| 10e. STREET AND NUMBER 423 Watty Court | | | | 10f. ZIP CODE 21201 | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: Black | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (9-12) 12th College (1-4 or 5+) College (1-4 or 5+) | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Janitorial | | 16b. KIND OF BUSINESS/INDUSTRY None | | | |
| 17. FATHER'S NAME (First, Middle, Last) David T. Kelly | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Cloria A. Harris | | | |
| 19a. INFORMANT'S NAME (Type/Print) Douglas Kelly (Brother) | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1975 Daisy Road, Woodbine, MD 21797 | | | |
| 20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Metropolitan Crematory 7/3 | | DATE | | 20c. LOCATION — City or Town, State Alexandria, VA | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>George K. Snowden</i> | | | | 22. NAME AND ADDRESS OF FACILITY SNOWDEN FUNERAL HOME, P.A. ROCKVILLE, MD 20850 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. MULTIPLE GUNSHOT WOUNDS DUE TO (OR AS A CONSEQUENCE OF): Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST { b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) at scene | | | | | |
| 27. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) 6 29 95 | | 28b. TIME OF INJURY 0348AM | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED SHOOTING | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) APARTMENT | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) 311 CATHEDRAL ST. BALTIMORE MD | | | |
| 29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER <i>Margaret M. Kroll M.D.</i> | | | | 29c. LICENSE NUMBER O.C.M.E. | | 29d. DATE SIGNED (Month, Day, Year) June 29 1995 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Margarita Korell M.D. 111 Penn Street, Baltimore, Maryland 21201 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JUL 07 1995 | | 32. REGISTRAR'S SIGNATURE <i>John Davidson Randall</i> | | | | | |

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

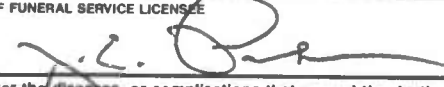

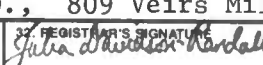
TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

95 21970

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) Mary Juliet Kleinguenther | | | | 2. DATE OF DEATH MONTH DAY YEAR July 4, 1995 | | 3. TIME OF DEATH 5:00 a. M | |
| 4. SOCIAL SECURITY NUMBER 199-18-6348 | | 5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 89 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) June 1, 1906 | |
| 8. BIRTHPLACE (State or Foreign Country) Pennsylvania | | | | 9a. FACILITY NAME (If not institution, give street and number) 4900 McCall Street | | 9b. CITY, TOWN OR LOCATION OF DEATH Rockville | |
| 9c. COUNTY OF DEATH Montgomery | | | | 10a. STATE Maryland | | 10b. COUNTY Montgomery | |
| 10c. CITY, TOWN OR LOCATION Rockville | | | | 10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 10e. STREET AND NUMBER 4900 McCall Street | |
| 10f. ZIP CODE 20853 | | | | 10g. CITIZEN OF WHAT COUNTRY? United States | | 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | | |
| 14. RACE — American Indian, Black, White, etc. Specify: White | | | | 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 6 College (1-4 or 5+) 6 | | | |
| 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Home Maker | | | | 16b. KIND OF BUSINESS/INDUSTRY Own Home | | | |
| 17. FATHER'S NAME (First, Middle, Last) James | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Anne Mc Cleaster | | | |
| 19a. INFORMANT'S NAME (Type/Print) George H. Kleinguenther, Jr. | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4900 McCall Street, Rockville, Maryland 20853 | | | |
| 20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Metropolitan Crematory 7/4 | | | |
| 20c. LOCATION — City or Town, State Alexandria, Virginia | | | | 21. SIGNATURE OF FUNERAL SERVICE LICENSEE  | | | |
| 22. NAME AND ADDRESS OF FACILITY DeVol Funeral Home 10 E. Deer Park Dr., Gaithersburg, MD 20877 | | | | 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <u>pneumonitis</u> DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>bronchogenic carcinoma</u> | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 6 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide | | | | 28a. DATE OF INJURY (Month, Day, Year) 28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO 28d. DESCRIBE HOW INJURY OCCURRED 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | 29b. SIGNATURE AND TITLE OF CERTIFIER  29c. LICENSE NUMBER D00957 29d. DATE SIGNED (Month, Day, Year) July 4, 1995 | | | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Donald L. Bucy, M.D., 809 Veirs Mill Road #101, Rockville, Maryland 20851 | | | | 31. DATE FILED (Month, Day, Year) JUL 06 1995 32. REGISTRAR'S SIGNATURE  | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 687600 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 21971

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) Hampartzoum Kehyaian | | | | 2. DATE OF DEATH MONTH DAY YEAR July 3 1995 | | 3. TIME OF DEATH 3:00 A M | |
| 4. SOCIAL SECURITY NUMBER 577-54-1737 | | 5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 87 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) April 1, 1908 | |
| 9a. FACILITY NAME (If not institution, give street and number) 800 Elm Avenue | | 9b. CITY, TOWN OR LOCATION OF DEATH Takoma Park | | 9c. COUNTY OF DEATH Prince George | | | |
| 10a. STATE Maryland | | 10b. COUNTY Prince George | | 10c. CITY, TOWN OR LOCATION Takoma Park | | 10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| 10a. STREET AND NUMBER 800 Elm Avenue | | | | 10f. ZIP CODE 20912 | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 6 College (1-4 or 5+) 6 | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Carpet Layer | | 16b. KIND OF BUSINESS/INDUSTRY Carpet | | | |
| 17. FATHER'S NAME (First, Middle, Last) Hovhannes Kehyaian | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Yeva Arabian | | | |
| 19a. INFORMANT'S NAME (Type/Print) Louise Kehyaian | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2900 Gracefield Road Silver Spring, Maryland 20904 | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Gate of Heaven Cemetery 7/6/95 | | 20c. LOCATION — City or Town, State Silver Spring, Maryland | | 20d. DATE 7/6/95 | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | | | | 22. NAME AND ADDRESS OF FACILITY Francis J. Collins Funeral Home, Inc. 500 University Blvd., W. Sil. Spr., MD 20901 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <u>Arteriosclerotic heart Disease</u> DUE TO (OR AS A CONSEQUENCE OF): b. _____ DUE TO (OR AS A CONSEQUENCE OF): c. _____ DUE TO (OR AS A CONSEQUENCE OF): d. _____ Approximate Interval Between Onset and Death years | | | | | | | 23. PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>Emphysema</u> |
| 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? YES <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| 28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28d. DESCRIBE HOW INJURY OCCURRED | | | |
| 29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER | | | | 29c. LICENSE NUMBER 208546 | | 29d. DATE SIGNED (Month, Day, Year) July 3 95 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) John Tumber 8218 Wisconsin Ave Bethesda Md. | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JUL 06 1995 | | 32. REGISTRAR'S SIGNATURE | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95-2635-033

DWG

ITEMS: 23 PART I, 27, PER MEO FILM g-725 7/28/95 t.t

95 21972

FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|--|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) ANTHONY D. KELLY | | | | 2. DATE OF DEATH MONTH MAY DAY 07 YEAR 95 | | 3. TIME OF DEATH 1:10A M | |
| 4. SOCIAL SECURITY NUMBER 219 96 8796 | | 5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 27 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) Nov 20, 1967 | |
| 8. BIRTHPLACE (State or Foreign Country) Virginia | | | | 9a. FACILITY NAME (If not institution, give street and number) 1007 JANSEN AVENUE | | 9b. CITY, TOWN OR LOCATION OF DEATH CAPITOL HEIGHTS | |
| 9c. COUNTY OF DEATH PRINCE GEORGES | | | | 10a. STATE MD | | 10b. COUNTY Prince George's | |
| 10c. CITY, TOWN OR LOCATION Capitol Heights | | | | 10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | 10e. STREET AND NUMBER 1007 Jansen Avenue | |
| 10f. ZIP CODE 20743 | | | | 10g. CITIZEN OF WHAT COUNTRY? USA | | 11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: Black | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 12 | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Computer Analyst | | 16b. KIND OF BUSINESS/INDUSTRY Computer Management | |
| 17. FATHER'S NAME (First, Middle, Last) Roger Kelly | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Lorraine Murray | | | |
| 19a. INFORMANT'S NAME (Type/Print) Roger Kelly | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12014 Hickory Dr, Ft Wash., MD 20744 | | | |
| 20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input checked="" type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Mt. Comfort Cemetery 8MAY | | 20c. LOCATION — City or Town, State Fairfax CO., Virginia | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>John E. Greene</i> | | | | 22. NAME AND ADDRESS OF FACILITY Greene Funeral Home Inc 814 Franklin ST, Alexandria, VA 22314 | | | |
| 23. PART I. Enter the diseases, or complications, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. RENAL FAILURE DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | |
| 27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | |
| 28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO | | | | 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | 29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER <i>Walter M. Melville</i> | | | | 29c. LICENSE NUMBER O.C.M.E. | | 29d. DATE SIGNED (Month, Day, Year) MAY 07/95 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Marysarah B. Kordeck 111 PENN STREET, BALTIMORE, MARYLAND 21201 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JUN 26 1995 | | | | 32. REGISTRAR'S SIGNATURE <i>John Davidson-Randall</i> | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 21973

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | |
|--|--|--|--|---|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) <i>Mary Ketts</i> | | | | 2. DATE OF DEATH MONTH <i>June</i> DAY <i>22</i> YEAR <i>1995</i> | | | | 3. TIME OF DEATH <i>5:25P</i> M | |
| 4. SOCIAL SECURITY NUMBER <i>529-46-4286</i> | | 5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) <i>80</i> YRS. | | IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. | | 7. DATE OF BIRTH (Month, Day, Year) <i>Sept. 23, 1914</i> | |
| 9a. FACILITY NAME (If not institution, give street and number) <i>Southern Maryland Hospital</i> | | | | 9b. CITY, TOWN OR LOCATION OF DEATH <i>Clinton</i> | | | | 9c. COUNTY OF DEATH <i>Prince George's</i> | |
| 10a. STATE <i>Maryland</i> | | | | 10b. COUNTY <i>Prince George's</i> | | 10c. CITY, TOWN OR LOCATION <i>Aquasco</i> | | | |
| 10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | 10e. STREET AND NUMBER <i>18100 At Last Farm Road</i> | | | | 10f. ZIP CODE <i>20608</i> | |
| 10g. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i> | | | | 11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | |
| 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | | | 14. RACE — American Indian, Black, White, etc. Specify: <i>White</i> | | | | 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <i>3.5</i> College (1-4 or 5+) <i>3.5</i> | |
| 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <i>Homemaker</i> | | | | 16b. KIND OF BUSINESS/INDUSTRY <i>Own Home</i> | | | | 17. FATHER'S NAME (First, Middle, Last) <i>Thomas J. Welch</i> | |
| 18. MOTHER'S NAME (First, Middle, Maiden Surname) <i>Sarah Jane Gracey</i> | | | | 19a. INFORMANT'S NAME (Type/Print) <i>Harry C. Ketts III</i> | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>18100 At Last Farm Road, Aquasco, Maryland 20608</i> | |
| 20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <i>Metropolitan Crematory 06/24/95</i> | | | | 20c. LOCATION — City or Town, State <i>Alexandria, Virginia</i> | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>W.B. Geiser</i> | | | | 22. NAME AND ADDRESS OF FACILITY <i>Francis Gasch's Sons Funeral Home, P.A. 4739 Baltimore Ave., Hyattsville, MD 20781</i> | | | | 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>a. Pneumonia</i> DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST <i>b. DUE TO (OR AS A CONSEQUENCE OF):</i> <i>c. DUE TO (OR AS A CONSEQUENCE OF):</i> <i>d.</i> | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Arteriosclerotic cerebro-vascular disease gastric enteritis</i> | | | | 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | 27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide | |
| 28a. DATE OF INJURY (Month, Day, Year) | | | | 28b. TIME OF INJURY <i>M</i> | | | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | 29b. SIGNATURE AND TITLE OF CERTIFIER <i>Augusto P. Rodriguez M.D.</i> | | | | 29c. LICENSE NUMBER <i>D21230</i> | |
| 29d. DATE SIGNED (Month, Day, Year) <i>June 23, 1995</i> | | | | 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>Augusto P. Rodriguez, M.D. 5009 Rayburn Ct. Camp Springs, MD 20748</i> | | | | 31. DATE FILED (Month, Day, Year) <i>JUN 26 1995</i> | |
| 32. REGISTRAR'S SIGNATURE <i>John A. Swanson-Rodell</i> | | | | | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 21974

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|--|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) Albert V. Kentrus | | | | 2. DATE OF DEATH MONTH DAY YEAR July 4 1995 | | 3. TIME OF DEATH 6:15 PM M | |
| 4. SOCIAL SECURITY NUMBER 163-28-3031 | | 5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 57 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) Aug. 6, 1937 | |
| 8. BIRTHPLACE (State or Foreign Country) Pennsylvania | | | | 9a. FACILITY NAME (If not institution, give street and number) 910 Eastham Court | | 9b. CITY, TOWN OR LOCATION OF DEATH Crofton | |
| 9c. COUNTY OF DEATH Anne Arundel | | | | 10a. STATE Maryland | | 10b. COUNTY Anne Arundel | |
| 10c. CITY, TOWN OR LOCATION Crofton | | | | 10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 10e. STREET AND NUMBER 910 Eastham Court | |
| 10f. ZIP CODE 21114 | | | | 10g. CITIZEN OF WHAT COUNTRY? United States | | 11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 12 | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Parts Manager | | 16b. KIND OF BUSINESS/INDUSTRY Electrical Contractor | |
| 17. FATHER'S NAME (First, Middle, Last) Albert J. Kentrus | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Katherine Mc Dunnough | | | |
| 19a. INFORMANT'S NAME (Type/Print) Albert Kentrus Jr. | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 732 Whitesands Drive Lusby Md. 20657 | | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Maryland Veterans Cemetery 7/7/95 Cheltenham Md. | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Robert E. Evans Funeral Home, P.A. 16000 Annapolis Rd. Bowie Md. 20715 | | | | 22. NAME AND ADDRESS OF FACILITY Robert E. Evans Funeral Home, P.A. 16000 Annapolis Rd. Bowie Md. 20715 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | | | | | | | |
| a. <u>CHF Congestive Heart Failure</u> | | | | | | | |
| b. <u>HASCN arteriosclerotic cardio</u> | | | | | | | |
| c. <u>hypertension independent</u> | | | | | | | |
| d. <u>diabetes mellitus</u> | | | | | | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | | | | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | | | 28a. DATE OF INJURY (Month, Day, Year) 28b. TIME OF INJURY M 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | 29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER Michael J. LaPorta M.D. | | | | 29c. LICENSE NUMBER D21438 | | | |
| 29d. DATE SIGNED (Month, Day, Year) 7/6/95 | | | | 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type/Print) MICHAEL J. LaPorta M.D. 600 RING ELY AVE STE 20 ANNAPOLIS MARYLAND | | | |
| 31. DATE FILED (Month, Day, Year) JUL 06 1995 | | | | 32. REGISTRAR'S SIGNATURE John A. ... | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 21975

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|---|--|--|--|--|---|
| 1. DECEDENT'S NAME (First, Middle, Last) DAVID N. KALLOO | | | | 2. DATE OF DEATH MONTH JULY DAY 3 YEAR 1995 | | 3. TIME OF DEATH 16:30 PM | |
| 4. SOCIAL SECURITY NUMBER 217- 19-9739 | | 5. SEX XX M 2 F | | 6. AGE (In yrs. last birthday) 33 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) SEPT. 28, 1961 | |
| 9a. FACILITY NAME (If not institution, give street and number) THE JOHNS HOPKINS HOSPITAL | | | | 9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE CITY | | 9c. COUNTY OF DEATH BALTIMORE | |
| RESIDENCE OF DECEDENT | | | | | | | |
| 10a. STATE MARYLAND | | 10b. COUNTY PRINCE GEORGE'S | | 10c. CITY, TOWN OR LOCATION GLENNDAL | | 10d. INSIDE CITY LIMITS? 1 X YES 2 NO | |
| 10e. STREET AND NUMBER 10708 FORESTGATE PLACE | | | | 10f. ZIP CODE 20769 | | 10g. CITIZEN OF WHAT COUNTRY? USA | |
| 11. MARITAL STATUS 1 X Never Married 2 Married 3 Widowed 4 Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 X NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 YES 2 X NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: BLACK | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 4YRS. | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) LAB TECHNICIAN | | 16b. KIND OF BUSINESS/INDUSTRY PVT. | | | |
| 17. FATHER'S NAME (First, Middle, Last) EMANUEL KALLOO | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) VERONICA RAMIREZ | | | |
| 19a. INFORMANT'S NAME (Type/Print) EMANUEL KALLOO/ FATHER | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10708 FORESTGATE PLACE GLENNDAL, MARYLAND 20769 | | | |
| 20a. METHOD OF DISPOSITION 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) HARMONY MEMORIAL PARK | | DATE 7-5-95 | | 20c. LOCATION — City or Town, State LANDOVER, MD | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Shawana L. Braxton</i> | | | | 22. NAME AND ADDRESS OF FACILITY J.B. JENKINS FUNERAL HOME 7474 LANDOVER ROAD LANDOVER, MD 20785 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <i>SEPSIS</i> DUE TO (OR AS A CONSEQUENCE OF): b. <i>CHRONIC MYELOID LEUKEMIA</i> DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | | Approximate Interval Between Onset and Death 1 day 8 years |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 YES 2 X NO |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO X UNCERTAIN | | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 X NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 X NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 X Inpatient 2 ER/Outpatient 3 DOA OTHER: 4 Nursing Home 5 Residence 6 Other (Specify) | | | | | |
| 27. MANNER OF DEATH 1 X Natural 5 Pending Investigation 2 Accident 6 Could not be determined 3 Suicide 4 Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 YES 2 NO | |
| | | 28d. DESCRIBE HOW INJURY OCCURRED | | | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | |
| | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | |
| 29a. CERTIFIER (Check only) 1 X CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER <i>Philip A. Burke</i> | | | | 29c. LICENSE NUMBER A4446 | | 29d. DATE SIGNED (Month, Day, Year) 7/3/95 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) JOHNS HOPKINS HOSPITAL - 600 N WOLFE ST BALTIMORE MD 21287 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JUL 05 1995 | | | | 32. REGISTRAR'S SIGNATURE <i>John Anderson-Randall</i> | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 21976

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|--|--|---|--|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last) <i>William Henry Kelliebrew</i> | | | | 2. DATE OF DEATH MONTH <i>June</i> DAY <i>27</i> YEAR <i>1995</i> | | 3. TIME OF DEATH <i>4:56A</i> M | |
| 4. SOCIAL SECURITY NUMBER <i>717-09-8380</i> | | 5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) <i>79</i> YRS. | | 7. DATE OF BIRTH (Month, Day, Year) <i>April 13, 1916</i> | |
| 9a. FACILITY NAME (If not institution, give street and number) <i>Doctor's Hospital</i> | | | | 9b. CITY, TOWN OR LOCATION OF DEATH <i>Lanham</i> | | 9c. COUNTY OF DEATH <i>Prince George's</i> | |
| 10a. STATE <i>Maryland</i> | | 10b. COUNTY <i>Prince George's</i> | | 10c. CITY, TOWN OR LOCATION <i>Capitol Heights</i> | | 10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 10e. STREET AND NUMBER <i>5217 Addison Road</i> | | | | 10f. ZIP CODE <i>20743</i> | | 10g. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i> | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: <i>Black</i> | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <i>6th grade</i> College (1-4 or 5+) <i></i> | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <i>Truck Driver</i> | | 16b. KIND OF BUSINESS/INDUSTRY <i>Federal Government</i> | | | |
| 17. FATHER'S NAME (First, Middle, Last) <i>William H. Kelliebrew, Sr.</i> | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) <i>Oddie Kelliebrew</i> | | | |
| 19a. INFORMANT'S NAME (Type/Print) <i>Mrs. Leanora Lee Kelliebrew (Wife)</i> | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>5217 Addison Road Capitol Heights, Maryland 20743</i> | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <i>Maryland Veterans Cemetery July 3, 1995</i> | | 20c. LOCATION — City or Town, State <i>Cheltenham, Maryland</i> | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i> | | | | 22. NAME AND ADDRESS OF FACILITY <i>Rollins Funeral Home, Inc. 4339 Hunt Place, N.E. Washington, D.C. 20019</i> | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>BOWEL OBSTRUCTION</i> DUE TO (OR AS A CONSEQUENCE OF): a. <i>BOWEL OBSTRUCTION</i> b. <i>INFLAMMATORY BOWEL DISEASE</i> c. <i>METASTATIC HEPATOMA</i> d. <i></i> Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | | Approximate Interval Between Onset and Death <i>Hours</i> <i>months</i> <i>months</i> |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>DIABETES MELLITUS</i> <i>CARDIO MYOPATHY</i> | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | | | | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY <i>M</i> | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| 29. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29a. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i> | | | | 29c. LICENSE NUMBER <i>MD31069</i> | | 29d. DATE SIGNED (Month, Day, Year) <i>6/28/95</i> | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>Dr. George Bone 9602F M.L. King Jr Highway Lanham, MD 20706</i> | | | | | | | |
| 31. DATE FILED (Month, Day, Year) <i>JUL 03 1995</i> | | | | 32. REGISTRAR'S SIGNATURE <i>[Signature]</i> | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 21977

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) JACKIE L. KIMMEY | | | | 2. DATE OF DEATH MONTH DAY YEAR July 6 1995 | | 3. TIME OF DEATH 6:55 AM | |
| 4. SOCIAL SECURITY NUMBER 212-40-9801 | | 5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 52 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) July 13 1942 | |
| 8. BIRTHPLACE (State or Foreign Country) Maryland | | 9a. FACILITY NAME (If not institution, give street and number) Mallard Bay Nursing Home | | 9b. CITY, TOWN OR LOCATION OF DEATH CAMBRIDGE | | 9c. COUNTY OF DEATH Dorchester | |
| 10a. STATE Maryland | | 10b. COUNTY Dorchester | | 10c. CITY, TOWN OR LOCATION Cambridge | | 10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | |
| 10e. STREET AND NUMBER 208 Franklin St. | | 10f. ZIP CODE 21613 | | 10g. CITIZEN OF WHAT COUNTRY? | | | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: white | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) unknown College (14 or 5+) | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) carpenter | | 16b. KIND OF BUSINESS/INDUSTRY homebuilding | | | |
| 17. FATHER'S NAME (First, Middle, Last) Thomas William Kimmey | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Grace Lidden | | | |
| 19a. INFORMANT'S NAME (Type/Print) Joyce K. Windsor | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5147 Cordtown Rd., Cambridge MD 21613 | | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) E. New Market Cemetery 7/8 | | 20c. LOCATION — City or Town, State E. New Market Md. | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Kenneth R. Thomas Jr. | | | | 22. NAME AND ADDRESS OF FACILITY Thomas Funeral Home 700 Locust St. Cambridge MD 21613 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Squamous Cell Carcinoma of Lung DUE TO (OR AS A CONSEQUENCE OF): Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. | | | | | | Approximate Interval Between Onset and Death 12 months | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Chronic Obstructive Pulmonary Disease | | | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| | | 28d. DESCRIBE NOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER Edmund J. MacLaughlin MD | | | | 29c. LICENSE NUMBER D-28209 | | 29d. DATE SIGNED (Month, Day, Year) July 6, 1995 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Edmund J. MacLaughlin 4 Aurora St Cambridge, MD 21613 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JUL 07 1995 | | 32. REGISTRAR'S SIGNATURE Julia Shuckler Randall | | | | | |

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

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1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) Marian T. Lambert | | | | 2. DATE OF DEATH MONTH DAY YEAR June 29, 1995 | | 3. TIME OF DEATH 8:55 P M | |
| 4. SOCIAL SECURITY NUMBER 216-38-6213 | | 5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 72 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) May 7, 1923 | |
| 9a. FACILITY NAME (If not institution, give street and number) Montgomery General Hospital | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Olney | | 9c. COUNTY OF DEATH Montgomery | |
| 10a. STATE Maryland | | | | 10b. COUNTY Montgomery | | 10c. CITY, TOWN OR LOCATION Gaithersburg | |
| 10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | | | | |
| 10e. STREET AND NUMBER 8811 Swallow Court | | | | 10f. ZIP CODE 20879 | | 10g. CITIZEN OF WHAT COUNTRY? United States | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) - | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Homemaker | | 16b. KIND OF BUSINESS/INDUSTRY Own Home | | | |
| 17. FATHER'S NAME (First, Middle, Last) Henry Clayton Trigger | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Thelma M. Allison | | | |
| 19a. INFORMANT'S NAME (Type/Print) Patricia Roberts | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12113 Portree Drive, Rockville, Maryland 20852 | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Parklawn Memorial Park July 3, 1995 | | 20c. LOCATION — City or Town, State Rockville, Maryland | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Michelle P. Kutta</i> M00348 | | | | 22. NAME AND ADDRESS OF FACILITY Robert A. Pumphrey Funeral Home/Rockville, Inc., 300 W. Montgomery Ave Rockville, Maryland 20850-2805 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Intraabdominal abscess DUE TO (OR AS A CONSEQUENCE OF): b. Bowel (Colon) Perforation DUE TO (OR AS A CONSEQUENCE OF): c. Colon Cancer DUE TO (OR AS A CONSEQUENCE OF): d. Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | | Approximate interval Between Onset and Death 4 days 4 days 4 mon |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Diabetes Mellitus Coronary Artery disease | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 28d. DESCRIBE NOW INJURY OCCURRED | | | | 28e. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER <i>Dennis M. Hannon MD</i> | | | | 29c. LICENSE NUMBER D23124 | | 29d. DATE SIGNED (Month, Day, Year) JUL 30 1995 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Dennis M. Hannon MD 3416 OLANWOOD COURT OLNEY MD 20832 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JUL 08 1995 | | | | 32. REGISTRAR'S SIGNATURE <i>Julia Duckworth-Randall</i> | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Amended #13

7/6/95 MRT Montgomery County

95 21979

1 -
FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | |
|---|--|--|--|---|--|---|---|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) Harold W. Lincoln | | | | 2. DATE OF DEATH MONTH June DAY 26 , 1995 YEAR | | 3. TIME OF DEATH 4:30 P.M. | | | |
| 4. SOCIAL SECURITY NUMBER 525-60-4438 | | 5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 83 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) FEB. 10, 1912 | | 8. BIRTHPLACE (State or Foreign Country) LEXINGTON, NE. | |
| 9a. FACILITY NAME (If not institution, give street and number) 4701 WILLARD AVE. APT. # 235 | | | | 9b. CITY, TOWN OR LOCATION OF DEATH CHEVY CHASE | | | 9c. COUNTY OF DEATH MONTGOMERY | | |
| 10a. STATE MARYLAND | | | | 10b. COUNTY MONTGOMERY | | 10c. CITY, TOWN OR LOCATION CHEVY CHASE | | 10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 10e. STREET AND NUMBER 4701 WILLARD AVE APT # 235 | | | | 10f. ZIP CODE 20815 | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | | | |
| 11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES WWII | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO Specify: | | | 14. RACE — American Indian, Black, White, etc. Specify: WHITE | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 5+ College (1-4 or 5+) 5+ | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) ATTORNEY | | | 16b. KIND OF BUSINESS/INDUSTRY CONSULTING | | |
| 17. FATHER'S NAME (First, Middle, Last) GEORGE LINCOLN | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) UNKNOWN | | | | | |
| 19a. INFORMANT'S NAME (Type/Print) FRANCIS G. McGUIRE | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5401 WESTBARD AVE # 1412 BETHESDA, MD. 20816 | | | | | |
| 20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) MT. COMFORT CREMATORY | | DATE 6/29 | | 20c. LOCATION — City or Town, State ALEXANDRIA, VA. | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i> | | | | 22. NAME AND ADDRESS OF FACILITY JOSEPH GAWLER'S SONS, INC. 20016 5130 WISCONSIN AVE. N.W. WASHINGTON, D.C. | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Congestive Heart Failure DUE TO (OR AS A CONSEQUENCE OF): b. Anomalous Pulmonary Venous Return DUE TO (OR AS A CONSEQUENCE OF): c. Cardiac Arrhythmia DUE TO (OR AS A CONSEQUENCE OF): Approximate Interval Between Onset and Death 10 yrs 65 5 yrs. | | | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | |
| 27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED | |
| 28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| 29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER <i>David R. Laurey</i> | | | | 29c. LICENSE NUMBER 3347 | | 29d. DATE SIGNED (Month, Day, Year) 26 June 1995 | | | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 2) (Type, Print) DR. DAVID LORENZ 1145 19TH ST. N.W. WASHINGTON, D.C. 20036 | | | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JUL 06 1995 | | 32. REGISTRAR'S SIGNATURE <i>Johanna Davidson Randall</i> | | | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 21980

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) Roger Harrison Lapp | | | | 2. DATE OF DEATH MONTH DAY YEAR June 28 1995 | | 3. TIME OF DEATH 1130 a.m. | |
| 4. SOCIAL SECURITY NUMBER 485-16-3216 | | 5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 73 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) Aug. 17, 1921 | |
| 9a. FACILITY NAME (If not institution, give street and number) Shady Grove Adventist Hospital | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Rockville | | 9c. COUNTY OF DEATH Montgomery | |
| 10a. STATE Maryland | | | | 10b. COUNTY Montgomery | | 10c. CITY, TOWN OR LOCATION Gaithersburg | |
| 10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | | | | | | |
| 10e. STREET AND NUMBER 415 Russell Avenue Apt. #1117 | | | | 10f. ZIP CODE 20877 | | 10g. CITIZEN OF WHAT COUNTRY? United States | |
| 11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4 or 5+) <input checked="" type="checkbox"/> 5+ | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Mechanical Engineer | | 16b. KIND OF BUSINESS/INDUSTRY Mechanical Engineering | | | |
| 17. FATHER'S NAME (First, Middle, Last) Claude Jerome Lapp | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Blanche Harrison | | | |
| 19a. INFORMANT'S NAME (Type/Print) Alan R. Lapp | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2722 Munson Street, Wheaton, Maryland 20902 | | | |
| 20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Metropolitan Crematory | | DATE 7/1 | | 20c. LOCATION — City or Town, State Alexandria, Virginia | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | | | | 22. NAME AND ADDRESS OF FACILITY DeVol Funeral Home 10 E. Deer Park Dr., Gaithersburg, MD 20877 | | | |
| 23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | | a. acute Cardiac arrhythmia DUE TO (OR AS A CONSEQUENCE OF): | | | | | |
| | | b. Ischemic Heart Disease DUE TO (OR AS A CONSEQUENCE OF): | | | | | |
| | | c. DUE TO (OR AS A CONSEQUENCE OF): | | | | | |
| | | d. DUE TO (OR AS A CONSEQUENCE OF): | | | | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Chronic Renal Failure | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO | | | | | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/> | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO released | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| | | 28d. DESCRIBE NOW INJURY OCCURRED | | 28e. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER | | | | 29c. LICENSE NUMBER D20674 | | 29d. DATE SIGNED (Month, Day, Year) 6/28/95 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Steven Hedman 6240 Montrose Rd Rockville, Md 20852 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JUL 06 1995 | | 32. REGISTRAR'S SIGNATURE | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 21981

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) <i>William Lester Lepley</i> | | | | 2. DATE OF DEATH MONTH <i>June</i> DAY <i>29</i> YEAR <i>1995</i> | | 3. TIME OF DEATH <i>06:32A</i> | |
| 4. SOCIAL SECURITY NUMBER <i>563-36-3005</i> | | 5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) <i>88</i> YRS. | | 7. DATE OF BIRTH (Month, Day, Year) <i>June 4, 1907</i> | |
| 8. BIRTHPLACE (State or Foreign Country) <i>Pennsylvania</i> | | | | 9a. FACILITY NAME (If not institution, give street and number) <i>Shady Grove Adventist Hospital</i> | | 9b. CITY, TOWN OR LOCATION OF DEATH <i>Rockville</i> | |
| 9c. COUNTY OF DEATH <i>Montgomery</i> | | | | 10a. STATE <i>Maryland</i> | | 10b. COUNTY <i>Montgomery</i> | |
| 10c. CITY, TOWN OR LOCATION <i>Gaithersburg</i> | | | | 10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 10e. STREET AND NUMBER <i>18609 Walker's Choice Road #1</i> | |
| 10f. ZIP CODE <i>20879</i> | | | | 10g. CITIZEN OF WHAT COUNTRY? <i>United States</i> | | 11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES <i>WWII & Korean</i> | | | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: <i>White</i> | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) <i>Elementary/Secondary (0-12)</i> <i>12</i> | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <i>Mess Sergeant</i> | | 16b. KIND OF BUSINESS/INDUSTRY <i>U.S. Air Force</i> | |
| 17. FATHER'S NAME (First, Middle, Last) <i>James Lepley</i> | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) <i>Claudia Bigelow</i> | | | |
| 19a. INFORMANT'S NAME (Type/Print) <i>Ruth N. Lepley</i> | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>18609 Walkers Choice Rd. Apt #1, Gaithersburg, MD 20879</i> | | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <i>Arlington National Cem. 7/5/95</i> | | 20c. LOCATION — City or Town, State <i>Arlington, Virginia</i> | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Michael D. Gibbons</i> | | | | 22. NAME AND ADDRESS OF FACILITY <i>DeVol Funeral Home 10 East Deer Park Drive Gaithersburg, MD 20877</i> | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>asystole / Hypotension</i> | | | | | | | |
| DUE TO (OR AS A CONSEQUENCE OF): <i>intraventricular bleeding</i> | | | | | | | |
| DUE TO (OR AS A CONSEQUENCE OF): <i>Atherosclerosis</i> | | | | | | | |
| DUE TO (OR AS A CONSEQUENCE OF): <i>Diabetes / Hypertension</i> | | | | | | | |
| Approximate Interval Between Onset and Death <i>1 hour</i> <i>7 hour</i> <i>greater than 1 yr</i> <i>> 10 years</i> | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/> | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | |
| 27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY <i>M</i> | |
| 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | 28d. DESCRIBE HOW INJURY OCCURRED | | | |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER <i>Rushid Bynai Naini M.D.</i> | | | | 29c. LICENSE NUMBER <i>D39372</i> | | 29d. DATE SIGNED (Month, Day, Year) <i>JUNE 29 1995</i> | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>344 UNIVERSITY BLVD WEST SUITE 324 SILVERSPRING MD 20901</i> | | | | | | | |
| 31. DATE FILED (Month, Day, Year) <i>JUL 06 1995</i> | | | | 32. REGISTRAR'S SIGNATURE <i>Julia A. Havelock-Randall</i> | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

P.O. BOX 68760

127

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | | | |
|--|--|--|--|---|--|---|---|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) CORNELIO O. LOPEZ | | | | 2. DATE OF DEATH MONTH DAY YEAR JUNE 27 1995 | | 3. TIME OF DEATH 6:08 AM | | | | | |
| 4. SOCIAL SECURITY NUMBER 578-20-2927 | | 5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 91 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) June 14, 1904 | | 8. BIRTHPLACE (State or Foreign Country) Philippines | | | |
| 9a. FACILITY NAME (If not institution, give street and number) WASHINGTON ADVENTIST CENTER | | | | 9b. CITY, TOWN OR LOCATION OF DEATH TAKOMA PARK | | | 9c. COUNTY OF DEATH MONTGOMERY | | | | |
| RESIDENCE OF DECEDENT | | | | 10a. STATE Maryland | | 10b. COUNTY Prince George's | | 10c. CITY, TOWN OR LOCATION Hyattsville | | | |
| 10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | 10e. STREET AND NUMBER 2420 Fordham Place | | 10f. ZIP CODE 20783 | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | | | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | | 14. RACE — American Indian, Black, White, etc. Specify: Philippino | | | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 5+ | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Lawyer | | 16b. KIND OF BUSINESS/INDUSTRY Self-Employed | | | | | | | |
| 17. FATHER'S NAME (First, Middle, Last) Isidro Lopez | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Susana Orial | | | | | | | |
| 19a. INFORMANT'S NAME (Type/Print) Manuel R. Lopez | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2306 Lee Highway, Arlington, Virginia 22201 | | | | | | | |
| 20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Metropolitan Crematory 06/30/95 | | 20c. LOCATION — City or Town, State Alexandria, Virginia | | | | | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Charles F. Beebe | | | | 22. NAME AND ADDRESS OF FACILITY Francis Gasch's Sons Funeral Home, P.A. 4739 Baltimore Ave., Hyattsville, MD 20781 | | | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Smoke Inhalation DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. | | | | | | | | Approximate Interval Between Onset and Death | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | | | |
| 27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Could not be determined 4 <input checked="" type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) 6-27-95 | | 28b. TIME OF INJURY 0500 AM | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED House Fire - Arson | | | |
| 28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) Residence | | 28e. LOCATION (Street and Number or Rural Route Number, City or Town, State) 2420 Fordham PL Hyatts | | | | | | | | | |
| 29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. SIGNATURE AND TITLE OF CERTIFIER David R Fowler | | 29c. LICENSE NUMBER O.C.M.E. | | 29d. DATE SIGNED (Month, Day, Year) JUNE 28, 1995 | | | | | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) David R Fowler 111 Penn Street, Baltimore, Maryland 21201 | | | | | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JUL 06 1995 | | | | 32. REGISTRAR'S SIGNATURE John Andrew Carroll | | | | | | | |

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician.
THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR

95 21983

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|---|--|---|--|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last) Mary K. Lambert | | | | 2. DATE OF DEATH MONTH DAY YEAR July 5, 1995 | | 3. TIME OF DEATH 12:05 P. M. | |
| 4. SOCIAL SECURITY NUMBER 579-34-1689 | | 5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 67 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) June 15, 1928 | |
| 9a. FACILITY NAME (If not institution, give street and number) 6104 Cabot St. | | | | 9b. CITY, TOWN OR LOCATION OF DEATH District Heights | | 9c. COUNTY OF DEATH Prince George's | |
| RESIDENCE OF DECEDENT | | | | | | | |
| 10a. STATE Maryland | | 10b. COUNTY Prince George's | | 10c. CITY, TOWN OR LOCATION District Heights | | 10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 10e. STREET AND NUMBER 6104 Cabot St. | | | | 10f. ZIP CODE 20747 | | 10g. CITIZEN OF WHAT COUNTRY? USA | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12th College (1-4 or 5+) College | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Secretary | | 16b. KIND OF BUSINESS/INDUSTRY Schools | | | |
| 17. FATHER'S NAME (First, Middle, Last) Norman C. King | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Lottie Dodson | | | |
| 19a. INFORMANT'S NAME (Type/Print) Norman E. Lambert | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) same as item 10 | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Resurrection Cemetery 7/10/95 | | DATE 7/10/95 | | 20c. LOCATION — City or Town, State Clinton, Md. | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>George P. Kalas</i> | | | | 22. NAME AND ADDRESS OF FACILITY George P. Kalas Funeral Home 6160 Oxon Hill Rd. Oxon Hill, Md. 20745 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. ACUTE MYELOGENOUS LEUKEMIA DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. | | | | | | | Approximate Interval Between Onset and Death 3 mos |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |
| 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER DENNIS A. PRIEBAT <i>Dennis A. Priebat</i> | | | | 29c. LICENSE NUMBER DL10200 | | 29d. DATE SIGNED (Month, Day, Year) 7/6/95 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 110 IRVING ST., NW WASHINGTON, DC 20010 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JUL 07 1995 | | | | 32. REGISTRAR'S SIGNATURE <i>John Anderson-Randall</i> | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

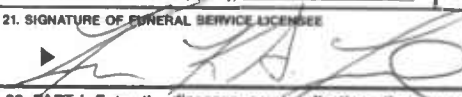
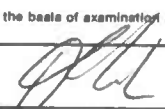
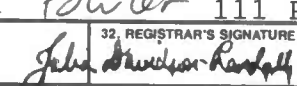
B.K.S.
95-2965-031

95 21984

1 - FOR
STATE
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | | | |
|--|--|---|--|---|--|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) MATTHEW DAVID LEE | | | | 2. DATE OF DEATH MONTH DAY YEAR MAY 22, 1995 | | 3. TIME OF DEATH 10:59 PM | | | | | |
| 4. SOCIAL SECURITY NUMBER 219-43-3255 | | 5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) YRS. MONTHS DAYS 01 12 | | 7. DATE OF BIRTH (Month, Day, Year) 04/10/95 | | 8. BIRTHPLACE (State or Foreign Country) Rockville, MD | | | |
| 9a. FACILITY NAME (If not institution, give street and number) HOLY CROSS HOSPITAL | | | | 9b. CITY, TOWN OR LOCATION OF DEATH SILVER SPRING | | | | 9c. COUNTY OF DEATH MONTGOMERY | | | |
| 10a. STATE Maryland | | | | 10b. COUNTY Montgomery | | 10c. CITY, TOWN OR LOCATION Rockville | | 10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | |
| 10e. STREET AND NUMBER 4902 Adrian Street | | | | 10f. ZIP CODE 20853 | | 10g. CITIZEN OF WHAT COUNTRY? United States | | | | | |
| 11. MARITAL STATUS 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: Black | | | | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) N/A N/A | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) N/A | | 16b. KIND OF BUSINESS/INDUSTRY N/A | | | | | | | |
| 17. FATHER'S NAME (First, Middle, Last) Vernon A. Lee | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Lisa Cooley | | | | | | | |
| 19a. INFORMANT'S NAME (Type/Print) Lisa Cooley | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4902 Adrian Street Rockville, MD 20853 | | | | | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Gate of Heaven Cemetery | | DATE 5/27 | | 20c. LOCATION — City or Town, State Silver Spring, MD | | | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE  #973 | | | | 22. NAME AND ADDRESS OF FACILITY Atlantis Long Funeral Services 20743 200 69th Pl., Seat Pleasant, MD | | | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. SUDDEN INFANT DEATH SYNDROME DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. | | | | | | | | Approximate Interval Between Onset and Death | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED | | | |
| 29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. SIGNATURE AND TITLE OF CERTIFIER  | | | | 29c. LICENSE NUMBER O.C.M.E. | | 29d. DATE SIGNED (Month, Day, Year) 7-7-95 | | | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) David R Fowler 111 Penn Street, Baltimore, Maryland 21201 | | | | | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JUL 07 1995 | | | | 32. REGISTRAR'S SIGNATURE  | | | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 21985

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|---|--|--|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) Belle F. Lunsford | | | | 2. DATE OF DEATH MONTH DAY YEAR June 22, 1995 | | 3. TIME OF DEATH 12:19 P M | |
| 4. SOCIAL SECURITY NUMBER 393-24-6484 | | 5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 88 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) Feb. 27, 1907 | |
| 8. BIRTHPLACE (State or Foreign Country) Illinois | | | | 9a. FACILITY NAME (If not institution, give street and number) Brooke Grove Nursing Home | | 9b. CITY, TOWN OR LOCATION OF DEATH Sandy Springs | |
| 9c. COUNTY OF DEATH Montgomery | | | | 10a. STATE Illinois | | 10b. COUNTY Lake | |
| 10c. CITY, TOWN OR LOCATION Lake Bluff | | | | 10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 10e. STREET AND NUMBER 318 1/2 Ravine Forest Drive | |
| 10f. ZIP CODE 60044 | | 10g. CITIZEN OF WHAT COUNTRY? United States | | 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | |
| 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White | | 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 12 | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Homemaker | |
| 16b. KIND OF BUSINESS/INDUSTRY Own Home | | 17. FATHER'S NAME (First, Middle, Last) John Edmund Feller | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Lieuzetta Jane Russell | | 19a. INFORMANT'S NAME (Type/Print) Suzanne McElvain | |
| 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 318 Ravine Forest Drive Lake Bluff, IL 60044 | | 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Mount Pleasant Cemetery 6/26 | | 20c. LOCATION — City or Town, State Terre Haute, Indiana | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE #M00690 Dowdell, Carson | | 22. NAME AND ADDRESS OF FACILITY Callahan & Hughes Funeral Home 605 S. 25th St. Terre Haute, Indiana 47803 | | 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Metastatic Liver Cancer b. Unknown Primary c. d. Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | Approximate Interval Between Onset and Death 2 Months | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER [Signature] | | 29c. LICENSE NUMBER D33700 | | 29d. DATE SIGNED (Month, Day, Year) June 22, 1995 | | 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Ted E. Howe, M. D. 18100 Slade School Road Sandy Spring, Maryland 20860 | |
| 31. DATE FILED (Month, Day, Year) JUN 28 1995 | | 32. REGISTRAR'S SIGNATURE [Signature] | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 21986

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) FRANCIS P Lanham | | | | 2. DATE OF DEATH MONTH DAY YEAR JUNE 30, 1995 | | 3. TIME OF DEATH 7:39am M | |
| 4. SOCIAL SECURITY NUMBER 217-14-7065 | | 5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | 6. AGE (In yrs. last birthday) 73 YRS. | 7. DATE OF BIRTH (Month, Day, Year) Feb. 28, 1922 | | 8. BIRTHPLACE (State or Foreign Country) Maryland | |
| 9a. FACILITY NAME (If not institution, give street and number) Washington Adventist Hospital | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Takoma Park | | 9c. COUNTY OF DEATH Montgomery | |
| RESIDENCE OF DECEDENT | | | | | | | |
| 10a. STATE Maryland | | 10b. COUNTY Prince George's | | 10c. CITY, TOWN OR LOCATION Hyattsville | | 10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 10e. STREET AND NUMBER 6803 Allison Street | | | | 10f. ZIP CODE 20784 | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES 1943-1944 | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: Black | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) 8th | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Cartographic Technician | | 16b. KIND OF BUSINESS/INDUSTRY Federal Government | | | |
| 17. FATHER'S NAME (First, Middle, Last) Brooke Lanham Sr. | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Susie Wood | | | |
| 19a. INFORMANT'S NAME (Type/Print) Maurice Lanham | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 15201 Noblewood Lane Bowie Maryland 20716 | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) July 5, 1995 Maryland Veterans Cem | | 20c. LOCATION — City or Town, State Cheltenham, MD | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | | | | 22. NAME AND ADDRESS OF FACILITY Lee Funeral Home, Inc. 6633 Old Alexandria Ferry Rd Clinton, Md 20735 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Ac Ventricular fibrillation DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST Acute myocardial infarction DUE TO (OR AS A CONSEQUENCE OF): Coronary atherosclerosis DUE TO (OR AS A CONSEQUENCE OF): Generalized atherosclerotic heart disease | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Chronic renal failure, poss. Aspiration pneumonia recurrent C.I. bleeding | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Nomicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28e. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER | | | | 29c. LICENSE NUMBER D24720 | | 29d. DATE SIGNED (Month, Day, Year) 6-30-95 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 6132 LANDOVER RD, CHEVERLY MD 20785 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JUL 06 1995 | | | | 32. REGISTRAR'S SIGNATURE | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 21987

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) Ronald Harold Leeper | | | | 2. DATE OF DEATH MONTH DAY YEAR June 28, 1995 | | 3. TIME OF DEATH 9:00PM M | |
| 4. SOCIAL SECURITY NUMBER 478-14-7467 | | 5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 75 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) Sept. 5, 1919 | |
| 9a. FACILITY NAME (If not institution, give street and number) 7407 Dryden Place | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Clinton | | 9c. COUNTY OF DEATH Prince George's | |
| 10a. STATE Maryland | | | | 10b. COUNTY Prince George's | | 10c. CITY, TOWN OR LOCATION Clinton | |
| 10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | | | | |
| 10e. STREET AND NUMBER 7407 Dryden Place | | | | 10f. ZIP CODE 20735 | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: Caucasian | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12th College (1-4 or 5+) N/A | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Printing/Book Binding | | 16b. KIND OF BUSINESS/INDUSTRY National Academy of Sciences | | | |
| 17. FATHER'S NAME (First, Middle, Last) J. Leon Leeper | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Grace Beavers | | | |
| 19a. INFORMANT'S NAME (Type/Print) Betty Leeper | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7407 Dryden Place Clinton, Maryland 20735 | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Leon Cemetery July 5, 1995 | | 20c. LOCATION — City or Town, State Leon Iowa | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Sh. G. Sitt | | | | 22. NAME AND ADDRESS OF FACILITY Lee Funeral Home, Inc. 6633 Old Alexandria Ferry Rd Clinton, Md 20735 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Squamous Cell Carcinoma of the Lung DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. | | | | | | | Approximate Interval Between Onset and Death 10 months |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | | | 29. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER Harvey I. Katzen | | | | 29c. LICENSE NUMBER D 20352 | | 29d. DATE SIGNED (Month, Day, Year) 6-28-95 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Dr Harvey I. Katzen 8926 Woodyard Rd. #201 Clinton MD | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JUL 06 1995 | | | | 32. REGISTRAR'S SIGNATURE John Andrew Randall | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 21988

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|--|--|--|---|
| 1. DECEDENT'S NAME (First, Middle, Last) <i>Warren R Leftwich</i> | | | | 2. DATE OF DEATH MONTH DAY YEAR <i>June 29, 1995</i> | | 3. TIME OF DEATH <i>8A</i> | |
| 4. SOCIAL SECURITY NUMBER <i>579-16-8169</i> | | 5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) <i>74</i> YRS. | | 7. DATE OF BIRTH (Month, Day, Year) <i>December 31, 1920</i> | |
| 8. BIRTHPLACE (State or Foreign) <i>Virginia</i> | | | | 9a. FACILITY NAME (If not institution, give street and number) <i>7810 Locris Court</i> | | 9b. CITY, TOWN OR LOCATION OF DEATH <i>Upper Marlboro</i> | |
| 9c. COUNTY OF DEATH <i>Prince George's</i> | | | | 10a. STREET AND NUMBER <i>7810 Locris Court</i> | | 10b. CITY, TOWN OR LOCATION <i>Upper Marlboro</i> | |
| 10c. STATE <i>Maryland</i> | | 10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 10e. ZIP CODE <i>20772</i> | | 10f. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i> | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: <i>Black</i> | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) <i>12th grade</i> | | 15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <i>Truck Driver</i> | | 15b. KIND OF BUSINESS/INDUSTRY <i>U.S. Government</i> | | | |
| 17. FATHER'S NAME (First, Middle, Last) <i>Thomas Leftwich</i> | | | | 16. MOTHER'S NAME (First, Middle, Maiden Surname) <i>Fannie Royal</i> | | | |
| 19a. INFORMANT'S NAME (Type/Print) <i>William Swan</i> | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>7810 Locris Court Upper Marlboro, Maryland 20772</i> | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of place, City or Town, State, Zip Code) <i>National Harmony Memorial Park July 5, 1995 Landover, Maryland</i> | | 20c. LOCATION — City or Town, State | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Spence C. Anderson</i> | | | | 22. NAME AND ADDRESS OF FUNERAL HOME <i>Rollins Funeral Home, Inc. 4339 Hunt Place, N.E. Washington, D.C. 20019</i> | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Intermittent cerebral cardiovascular disease</i> DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. | | | | | | | Approximate Interval Between Onset and Death <i>years.</i> |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | | | | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/> | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | 29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER <i>August P. Rodriguez MD</i> | | | | 29c. LICENSE NUMBER <i>21230</i> | | 29d. DATE SIGNED (Month, Day, Year) <i>June 30, 1995</i> | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>August P. Rodriguez MD, 5029 Rayburn Ct. Cap-Spr MD 20745</i> | | | | | | | |
| 31. DATE FILED (Month, Day, Year) <i>JUL 07 1995</i> | | | | 32. REGISTRAR'S SIGNATURE <i>John Anderson</i> | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 21989

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|---|--|---|--|--|---|
| 1. DECEDENT'S NAME (First, Middle, Last) <i>Ethel M. McDaniel</i> | | | | 2. DATE OF DEATH MONTH <i>July</i> DAY <i>01</i> YEAR <i>1995</i> | | 3. TIME OF DEATH <i>1:30 PM</i> | |
| 4. SOCIAL SECURITY NUMBER <i>579-28-8814</i> | | 5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) <i>79</i> YRS. | | 7. DATE OF BIRTH MONTH <i>Oct.</i> DAY <i>21</i> YEAR <i>1915</i> | |
| 9a. FACILITY NAME (If not institution, give street and number) <i>BROOKE GROVE NURSING HOME</i> | | | | 9b. CITY, TOWN OR LOCATION OF DEATH <i>OLNEY</i> | | 9c. COUNTY OF DEATH <i>MONTGOMERY</i> | |
| RESIDENCE OF DECEDENT | | | | | | | |
| 10a. STATE <i>MARYLAND</i> | | 10b. COUNTY <i>HOWARD</i> | | 10c. CITY, TOWN OR LOCATION <i>WOODBINE</i> | | 10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 10e. STREET AND NUMBER <i>2940 DUVALL ROAD</i> | | | | 10f. ZIP CODE <i>21797</i> | | 10g. CITIZEN OF WHAT COUNTRY? <i>UNITED STATES</i> | |
| 11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: <i>WHITE</i> | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <i>8</i> College (1-4 or 5+) <i>0</i> | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <i>BOOK BINDER</i> | | 16b. KIND OF BUSINESS/INDUSTRY <i>GOVERNMENT PRINTING OFFICE</i> | | | |
| 17. FATHER'S NAME (First, Middle, Last) <i>CARMEN TOBIN</i> | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) <i>VIRGINIA LYONS</i> | | | |
| 19a. INFORMANT'S NAME (Type/Print) <i>ROBERT LEE TOBIN, SR.</i> | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>2940 DUVALL ROAD WOODBINE, MARYLAND 21797</i> | | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <i>FT. LINCOLN CEMETERY 7/6/95</i> | | 20c. LOCATION — City or Town, State <i>BRENTWOOD, MARYLAND</i> | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Muriel H. Barber</i> | | | | 22. NAME AND ADDRESS OF FACILITY <i>MURIEL H. BARBER FUNERAL HOME 20882 P.O. BOX 5038 LAYTONSVILLE, MARYLAND</i> | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | | a. <i>Coronary Heart Failure</i> | | | | | Approximate Interval Between Onset and Death <i>1 year</i> |
| Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | b. <i>Hypertension arteriosclerotic Heart Disease</i> | | | | | <i>3 years</i> |
| | | c. _____ | | | | | |
| | | d. _____ | | | | | |
| | | PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Hypothyroidism; Uremia</i> | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY <i>M</i> | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| | | 28d. DESCRIBE HOW INJURY OCCURRED | | | | 28e. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER <i>Michael R. DeBardage M.D.</i> | | | | 29c. LICENSE NUMBER <i>DC1138</i> | | 29d. DATE SIGNED (Month, Day, Year) <i>7/1/95</i> | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>Michael R. DeBardage M.D. 13975 Connecticut Ave Silver Spring Md</i> | | | | | | | |
| 31. DATE FILED (Month, Day, Year) <i>JUL 03 1995</i> | | 32. REGISTRAR'S SIGNATURE <i>John Davidson-Randall</i> | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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95 21990

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) Thomas P. Maloney | | | | 2. DATE OF DEATH MONTH DAY YEAR June 29, 1995 | | 3. TIME OF DEATH 10:00 PM M | |
| 4. SOCIAL SECURITY NUMBER 218-56-2903 | | 5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 41 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) March 20, 1954 | |
| 9a. FACILITY NAME (If not institution, give street and number) 10304 Ridgemoor Drive | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Silver Spring | | 9c. COUNTY OF DEATH Montgomery | |
| 10a. STATE Maryland | | | | 10b. COUNTY Montgomery | | 10c. CITY, TOWN OR LOCATION Silver Spring | |
| 10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | | | | |
| 10e. STREET AND NUMBER 10304 Ridgemoor Drive | | | | 10f. ZIP CODE 20901 | | 10g. CITIZEN OF WHAT COUNTRY? United States | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 4 | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Ship Broker | | 16b. KIND OF BUSINESS/INDUSTRY Shipping | | | |
| 17. FATHER'S NAME (First, Middle, Last) Thomas Gerald Maloney | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Mary Beck | | | |
| 19a. INFORMANT'S NAME (Type/Print) Linda O. Maloney | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) Same as 10 | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Gate of Heaven Cemetery 7-3 | | 20c. LOCATION — City or Town, State Silver Spring, Maryland | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Ellen H. Rapp | | | | 22. NAME AND ADDRESS OF FACILITY Rapp Funeral Services, P. A. 933 Gist Avenue, Silver Spring, MD 20910 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Amyotrophic lateral sclerosis DUE TO (OR AS A CONSEQUENCE OF): Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. | | | | | | | Approximate Interval Between Onset and Death 4 yrs. |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) N/A | | 28b. TIME OF INJURY N/A M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| | | 28d. DESCRIBE HOW INJURY OCCURRED N/A | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) N/A | | | |
| | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) N/A | | | | | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER Gerald M. Gacad | | | | 29c. LICENSE NUMBER D17799 | | 29d. DATE SIGNED (Month, Day, Year) June 30, 1995 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Gerald M. Gacad, M. D., 6510 Kemilworth Avenue, #2700, Riverdale, MD 20737 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JUL 03 1995 | | | | 32. REGISTRAR'S SIGNATURE John Anderson-Randall | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

P.O. BOX 68760

20

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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95 21991

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) Chia-Ching Mok | | | | 2. DATE OF DEATH MONTH DAY YEAR June 20, 1995 | | 3. TIME OF DEATH 7:15 A M | |
| 4. SOCIAL SECURITY NUMBER None | | 5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 76 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) May 7, 1919 | |
| 9a. FACILITY NAME (If not institution, give street and number) Holy Cross Hospital | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Silver Spring | | 9c. COUNTY OF DEATH Montgomery | |
| RESIDENCE OF DECEDENT | | | | | | | |
| 10a. STATE Maryland | | 10b. COUNTY Montgomery | | 10c. CITY, TOWN OR LOCATION Bethesda | | 10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| 10e. STREET AND NUMBER 7016 Fawn Trail Court | | | | 10f. ZIP CODE 20817 | | 10g. CITIZEN OF WHAT COUNTRY? China | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: Asian | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) — College (1-4 or 5+) — — 5+ — | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Banker | | 16b. KIND OF BUSINESS/INDUSTRY Banking | | | |
| 17. FATHER'S NAME (First, Middle, Last) Lien-Sze Mok | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Wen-Shu Li | | | |
| 19a. INFORMANT'S NAME (Type/Print) Alice Ho Mok | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7016 Fawn Trail Court, Bethesda, Maryland 20817 | | | |
| 20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Montgomery Crematorium, Inc. June 28, 1995 | | 20c. LOCATION — City or Town, State Bethesda, Maryland | | 20d. DATE OATE | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Nichelle P. Kutta</i> M00348 | | | | 22. NAME AND ADDRESS OF FACILITY Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc. 7557 Wisconsin Ave. Bethesda, MD 20814-3501 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | | a. <i>acute stroke</i> | | | | | Approximate interval Between Onset and Death 2 days |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | b. <i>acute myocardial infarct</i> | | | | | 2 weeks |
| | | c. <i>arteriosclerotic heart disease</i> | | | | | 20 years |
| | | d. <i>Diabetes Mellitus</i> | | | | | 20 years |
| | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| | | 28d. DESCRIBE HOW INJURY OCCURED | | | | 28e. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER <i>T. Chaney M.D.</i> | | | | 29c. LICENSE NUMBER D13339 | | 29d. DATE SIGNED (Month, Day, Year) 6/20/95 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) T. CHANEY 8824 Cunningham Drive, Berwyn Heights, Md | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JUL 05 1995 | | | | 32. REGISTRAR'S SIGNATURE <i>John Davidson Randall</i> | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

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95 21992

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|--|--|---|--|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last) VICTORIA L. MEILLER | | | | 2. DATE OF DEATH MONTH <u>July</u> DAY <u>4</u> YEAR <u>1995</u> | | 3. TIME OF DEATH <u>5:10</u> P M | |
| 4. SOCIAL SECURITY NUMBER 124.10.2488 | | 5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 79 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) Feb. 15, 1916 | |
| 9a. FACILITY NAME (If not institution, give street and number) CARRIAGE HILL - BETHESDA | | | | 9b. CITY, TOWN OR LOCATION OF DEATH BETHESDA | | 9c. COUNTY OF DEATH MONTGOMERY | |
| RESIDENCE OF DECEDENT | | | | | | | |
| 10a. STATE Maryland | | 10b. COUNTY Montgomery | | 10c. CITY, TOWN OR LOCATION Bethesda | | 10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 10e. STREET AND NUMBER 5013 River Hill Road | | | | 10f. ZIP CODE 20816 | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) +5 | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Mathematician | | 16b. KIND OF BUSINESS/INDUSTRY Nautical Almanac Office U.S. Naval Observatory | |
| 17. FATHER'S NAME (First, Middle, Last) William Carl Fahnkow | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Lucy Clausen | | | |
| 19a. INFORMANT'S NAME (Type/Print) Robert E. Meiller | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5013 River Hill Road Bethesda, Md. 20816 | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Parklawn Memorial Park 7/7 | | 20c. LOCATION — City or Town, State Rockville, Md. | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Joseph Peters</i> | | | | 22. NAME AND ADDRESS OF FACILITY Joseph Gawler's Sons 5130 WI AVE N.W. WASHINGTON D.C. 20016 | | | |
| 23. PART I. Enter the diseases or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <u>metastatic carcinoma of</u> DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST { b. <u>gallbladder</u> DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Approximate interval Between Onset and Death | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |
| 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | | |
| 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 28d. DESCRIBE NOW INJURY OCCURRED | |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER <i>John T. ...</i> | | | | 29c. LICENSE NUMBER D08546 | | 29d. DATE SIGNED (Month, Day, Year) July 4 95 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) John T. ... 8218 Wisconsin Ave | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JUL 06 1995 | | | | 32. REGISTRAR'S SIGNATURE <i>John T. ...</i> | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

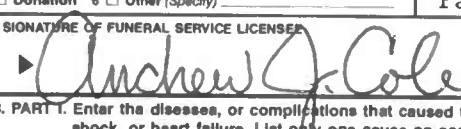

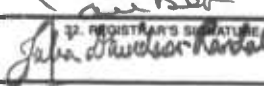
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 21993

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | | | | | | | | | | | |
|---|--|--|--|--|--|--|--|---|--|--------------------------------|--|---|--|---|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) Lola Bunker Mularkey | | | | 2. DATE OF DEATH MONTH DAY YEAR July 4 1995 | | | | 3. TIME OF DEATH 9:00 P.M. | | | | | | | | | | | |
| 4. SOCIAL SECURITY NUMBER 228-03-6172 | | | | 5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 89 YRS. | | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS. HOURS MIN. | | 7. DATE OF BIRTH (Month, Day, Year) June 13, 1906 | | 8. BIRTHPLACE (State or Foreign Country) Illinois | | | | | |
| 9a. FACILITY NAME (If not institution, give street and number) 3600 Glen Eagles Drive | | | | | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Silver Spring | | | | 9c. COUNTY OF DEATH Montgomery | | | | | | | |
| 10a. STATE Maryland | | | | 10b. COUNTY Montgomery | | | | 10c. CITY, TOWN OR LOCATION Silver Spring | | | | 10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | | | | |
| 10e. STREET AND NUMBER 3600 Glen Eagles Drive | | | | | | | | 10f. ZIP CODE 20906 | | | | 10g. CITIZEN OF WHAT COUNTRY? USA | | | | | | | |
| 11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | | | 14. RACE — American Indian, Black, White, etc. Specify: White | | | | | | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 12 | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Secretary | | | | 16b. KIND OF BUSINESS/INDUSTRY County Government | | | | | | | | | | | |
| 17. FATHER'S NAME (First, Middle, Last) Lyman Lyndon Bunker, M.D. | | | | | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Lola Mifs Lu Brasher | | | | | | | | | | | |
| 19a. INFORMANT'S NAME (Type/Print) Kathy Bignotti | | | | | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8217 Fort Hunt Road, Alexandria, VA 22308 | | | | | | | | | | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Parklawn Cemetery 7/8/95 | | | | 20c. LOCATION — City or Town, State Rockville, MD | | | | | | | | | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE  | | | | | | | | 22. NAME AND ADDRESS OF FACILITY Francis J. Collins Funeral Home, Inc. 500 University Blvd.W. Sil.Spr.MD 20901 | | | | | | | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. arteriosclerotic heart disease DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | | | | Approximate Interval Between Onset and Death years | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input type="checkbox"/> NO | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO | | | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | | | | | | | | | |
| 27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | | | 28a. DATE OF INJURY (Month, Day, Year) | | | | 28b. TIME OF INJURY M | | | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO | | | | 28d. DESCRIBE HOW INJURY OCCURED | | | |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | | | | | | | |
| 29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | | | | | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER  | | | | | | | | 29c. LICENSE NUMBER 208546 | | | | 29d. DATE SIGNED (Month, Day, Year) July 6 95 | | | | | | | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) John W. Sarsin 8218 W. Sarsin Ave | | | | | | | | | | | | | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JUL 07 1995 | | | | 32. REGISTRAR'S SIGNATURE  | | | | | | | | | | | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 21994

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|--|--|---|--|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last) <u>WILLIAM McCALLUM</u> | | | | 2. DATE OF DEATH MONTH <u>7</u> DAY <u>4</u> YEAR <u>95</u> | | 3. TIME OF DEATH <u>2:00 P M</u> | |
| 4. SOCIAL SECURITY NUMBER <u>213-44-2899</u> | | 5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) <u>80</u> YRS. | | 7. DATE OF BIRTH (Month, Day, Year) <u>Jan. 11, 1915</u> | |
| 8. BIRTHPLACE (State or Foreign Country) <u>Missouri</u> | | | | 9a. FACILITY NAME (If not institution, give street and number) <u>15 Hamilton Avenue</u> | | 9b. CITY, TOWN OR LOCATION OF DEATH <u>Silver Spring</u> | |
| 9c. COUNTY OF DEATH <u>Montgomery</u> | | | | 10a. STATE <u>Maryland</u> | | | |
| 10b. COUNTY <u>Montgomery</u> | | | | 10c. CITY, TOWN OR LOCATION <u>Silver Spring</u> | | | |
| 10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | 10e. STREET AND NUMBER <u>15 Hamilton Avenue</u> | | | |
| 10f. ZIP CODE <u>20901</u> | | | | 10g. CITIZEN OF WHAT COUNTRY? <u>USA</u> | | | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES <u>WW II</u> | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: <u>White</u> | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <u>12</u> College (1-4 or 5+) <u>4</u> | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <u>Director of Policy and Program Planning</u> | | 16b. KIND OF BUSINESS/INDUSTRY <u>U.S. Dept. of Transportation</u> | |
| 17. FATHER'S NAME (First, Middle, Last) <u>Donald McCallum</u> | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) <u>Nell Pixley</u> | | | |
| 19a. INFORMANT'S NAME (Type/Print) <u>Gwendolyn McCallum</u> | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>15 Hamilton Avenue, Silver Spring, Maryland 20901</u> | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <u>Gate of Heaven Cemetery</u> | | DATE <u>7/7</u> | | 20c. LOCATION — City or Town, State <u>Silver Spring, Maryland</u> | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <u>[Signature]</u> | | | | 22. NAME AND ADDRESS OF FACILITY <u>Hines-Rinaldi Funeral Home</u> <u>11800 New Hampshire Avenue</u> <u>Silver Spring, Maryland 20904</u> | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <u>ARTERIOSCLEROTIC HEART DISEASE</u> DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. _____ DUE TO (OR AS A CONSEQUENCE OF): c. _____ DUE TO (OR AS A CONSEQUENCE OF): d. _____ | | | | | | | Approximate Interval Between Onset and Death <u>YEARS</u> |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>CHRONIC OBSTRUCTIVE PULMONARY DISEASE</u> <u>DIABETES MELLITUS</u> DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide 3 <input type="checkbox"/> Homicide 8 <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY <u>M</u> | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER <u>[Signature] MD</u> | | | | 29c. LICENSE NUMBER <u>D15790</u> | | 29d. DATE SIGNED (Month, Day, Year) <u>7/5/95</u> | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <u>ARNOLD G. LEVY MD</u> <u>1106 SPRING ST., SILVER SPRING, MD. 20910</u> | | | | | | | |
| 31. DATE FILED (Month, Day, Year) <u>JUL 07 1995</u> | | 32. REGISTRAR'S SIGNATURE <u>[Signature]</u> | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 21995

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|--|--|---|--|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last) MARTHA MOHR | | | | 2. DATE OF DEATH MONTH DAY YEAR July 4 1995 | | 3. TIME OF DEATH 10:25 P M | |
| 4. SOCIAL SECURITY NUMBER 212-74-1144 | | 5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 95 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) Dec. 27, 1899 | |
| 9a. FACILITY NAME (If not institution, give street and number) Manor Care Nursing Center | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Silver Spring | | 9c. COUNTY OF DEATH Montgomery | |
| RESIDENCE OF DECEDENT | | | | | | | |
| 10a. STATE Maryland | | 10b. COUNTY Montgomery | | 10c. CITY, TOWN OR LOCATION Olney | | 10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| 10e. STREET AND NUMBER 17605 Prince Edward Drive | | | | 10f. ZIP CODE 20832 | | 10g. CITIZEN OF WHAT COUNTRY? USA | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 0 | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Homemaker | | 16b. KIND OF BUSINESS/INDUSTRY Own Home | | | |
| 17. FATHER'S NAME (First, Middle, Last) Franz Egert | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Eleanore Eckert | | | |
| 19a. INFORMANT'S NAME (Type/Print) Ralph Mohr | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 17605 Prince Edward Dr., Olney, Maryland 20832 | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Fort Lincoln Cemetery 7/7 | | 20c. LOCATION — City or Town, State Brentwood, Maryland | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Alan J. Donnell | | | | 22. NAME AND ADDRESS OF FACILITY Hines-Rinaldi Funeral Home 11800 New Hampshire Avenue Silver Spring, Maryland 20904 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Respiratory Distress Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST Cerebral Vascular Accident a. DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. | | | | | | | Approximate Interval Between Onset and Death |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DEMENTIA | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28d. DESCRIBE HOW INJURY OCCURRED | | | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. SIGNATURE AND TITLE OF CERTIFIER Rosie K. Singh | | 29c. LICENSE NUMBER 035824 | | 29d. DATE SIGNED (Month, Day, Year) 7/5/95 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Rosie K. Singh, M.D. 2415 Musgrove Road, Silver Spring, Maryland 20904 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JUL 07 1995 | | 32. REGISTRAR'S SIGNATURE John Davidson Randall | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 5 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 21996

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|---|--|---|--|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last) ANTWYON ANDREW McCALL | | | | 2. DATE OF DEATH MONTH DAY YEAR JUNE 29 1995 | | 3. TIME OF DEATH 1:05 A M | |
| 4. SOCIAL SECURITY NUMBER 579-96-2377 | | 5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 18 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 8-23-76 | |
| 9a. FACILITY NAME (If not institution, give street and number) FRANKLIN ST. & COLESVILLE RD. | | | | 9b. CITY, TOWN OR LOCATION OF DEATH SILVER SPRING | | 9c. COUNTY OF DEATH MONTGOMERY | |
| 10a. STATE Md | | | | 10b. COUNTY Prince Georges | | 10c. CITY, TOWN OR LOCATION Hyattsville | |
| 10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | | | | | | |
| 10e. STREET AND NUMBER 8033 New Riggs Road | | | | 10f. ZIP CODE 20783 | | 10g. CITIZEN OF WHAT COUNTRY? USA | |
| 11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: black | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12th College (1-4 or 5+) College (1-4 or 5+) | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Student | | 16b. KIND OF BUSINESS/INDUSTRY N/A | | | |
| 17. FATHER'S NAME (First, Middle, Last) UNKNOWN | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Delores Mc Call | | | |
| 19a. INFORMANT'S NAME (Type/Print) Delores McCall | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8033 New Riggs Road Hyattsville, Md. 20783 | | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Lincoln Memorial Cemetery 7-8 Suitland, Md. | | 20c. LOCATION — City or Town, State | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE J. P. Marshall | | | | 22. NAME AND ADDRESS OF FACILITY Marshall's Funeral Home, Inc. 4217 9th Street, N W Washington, D. C. 20011 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Multiple Trauma DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | | Approximate Interval Between Onset and Death |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | | | | | | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) scene of accident | | | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) 6 29 95 | | 28b. TIME OF INJURY 1 P M | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED Passenger in car struck tree | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) Roadway | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) Franklin Colesville Montgomery MD | | | |
| 29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. SIGNATURE AND TITLE OF CERTIFIER Monica McCall | | 29c. LICENSE NUMBER O.C.M.E. | | 29d. DATE SIGNED (Month, Day, Year) JUNE 29, 1995 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Maryland P. Koebe 111 Penn Street, Baltimore, Maryland 21201 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JUL 06 1995 | | 32. REGISTRAR'S SIGNATURE John Andrew Randall | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 21997

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | | | |
|---|--|--|--|--|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) <i>Margaret McAuliffe</i> | | | | 2. DATE OF DEATH MONTH DAY YEAR <i>July 1, 1995</i> | | | | 3. TIME OF DEATH <i>10:30 A M</i> | | | |
| 4. SOCIAL SECURITY NUMBER <i>215-46-1477</i> | | | | 5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) <i>88</i> YRS. | | IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. | | IF UNDER 24 HRS. HOURS MIN. | |
| 7. DATE OF BIRTH (Month, Day, Year) <i>Oct. 29, 1906</i> | | | | 8. BIRTHPLACE (State or Foreign Country) <i>Washington, DC</i> | | | | | | | |
| 9a. FACILITY NAME (If not institution, give street and number) <i>5512 Taylor Road</i> | | | | 9b. CITY, TOWN OR LOCATION OF DEATH <i>Riverdale</i> | | | | 9c. COUNTY OF DEATH <i>Prince George's</i> | | | |
| 10a. STATE <i>Maryland</i> | | | | 10b. COUNTY <i>Prince George's</i> | | | | 10c. CITY, TOWN OR LOCATION <i>Riverdale</i> | | | |
| 10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | | | | | | | | |
| 10e. STREET AND NUMBER <i>5512 Taylor Road</i> | | | | 10f. ZIP CODE <i>20737</i> | | | | 10g. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i> | | | |
| 11. MARITAL STATUS 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | | |
| 14. RACE — American Indian, Black, White, etc. Specify: <i>White</i> | | | | | | | | | | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <i>12</i> College (1-4 or 5+) <i>College</i> | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <i>Director</i> | | | | 16b. KIND OF BUSINESS/INDUSTRY <i>D.C. School System</i> | | | |
| 17. FATHER'S NAME (First, Middle, Last) <i>Maurice McAuliffe</i> | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) <i>Mable Hammer</i> | | | | | | | |
| 19a. INFORMANT'S NAME (Type/Print) <i>Nancy M. Washington</i> | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>2516 Painter Court, Annapolis, Maryland 21401</i> | | | | | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <i>Mt. Olivet Cemetery 7/05/95</i> | | | | 20c. LOCATION — City or Town, State <i>Washington, D.C.</i> | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Charles F. Bell</i> | | | | 22. NAME AND ADDRESS OF FACILITY <i>Francis Gasch's Sons Funeral Home, P.A. 4739 Baltimore Ave., Hyattsville, MD 20781</i> | | | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Arteriosclerotic cardiovascular disease</i> DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. | | | | | | | | | | Approximate interval Between Onset and Death <i>years</i> | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | | | | | | | | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/> | | | | | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide | | | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY <i>M</i> | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED | |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| 29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER <i>Augusto P. Rodriguez MD</i> | | | | 29c. LICENSE NUMBER <i>D 21230</i> | | | | 29d. DATE SIGNED (Month, Day, Year) <i>July 2, 1995</i> | | | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>Augusto P. Rodriguez MD, 5009 Rayburn Ct. Sp. Md 20746</i> | | | | | | | | | | | |
| 31. DATE FILED (Month, Day, Year) <i>JUL 06 1995</i> | | | | 32. REGISTRAR'S SIGNATURE <i>John Michael Riedel</i> | | | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) CYNTHIA M. MAYNARD | | | | 2. DATE OF DEATH MONTH June DAY 21 YEAR 1995 | | 3. TIME OF DEATH 6:45 P M | |
| 4. SOCIAL SECURITY NUMBER 579-62-2723 | | 5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 46 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) June 25, 1948 | |
| 8a. FACILITY NAME (If not institution, give street and number) 3206 Curtis Drive #6000 | | 9b. CITY, TOWN OR LOCATION OF DEATH Marlow Heights | | 9c. COUNTY OF DEATH Prince Georges | | | |
| 10a. STATE MD | | 10b. COUNTY Prince Georges | | 10c. CITY, TOWN OR LOCATION Marlow Heights | | 10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | |
| 10e. STREET AND NUMBER 3206 Curtis Drive #6000 | | | | 10f. ZIP CODE 20748 | | 10g. CITIZEN OF WHAT COUNTRY? USA | |
| 11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: Black | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 10th | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Disabled-N/A | | 16b. KIND OF BUSINESS/INDUSTRY | | | |
| 17. FATHER'S NAME (First, Middle, Last) Neil Johnson | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Mary Hall | | | |
| 19a. INFORMANT'S NAME (Type/Print) Neil Johnson | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1215 Alabama Ave. SE #202, Washington, D.C. 20019 | | | |
| 20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory, or other place) Metropolitan Crematory 6/30 | | 20c. LOCATION — City or Town, State Alexandria, VA | | 20d. DATE 6/30 | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE J. P. Marshall | | | | 22. NAME AND ADDRESS OF FACILITY Marshall's Funeral Home, Inc. 4308 Suitland Rd., Suitland, MD 20746 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. ACUTE COCAINE AND ALCOHOL INTOXICATION ASSOCIATED WITH HYPERTENSIVE ATHEROSCLEROTIC CARDIOVASCULAR DISEASE | | | | | | | Approximate Interval Between Onset and Death |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | | | | | | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH <input type="checkbox"/> Natural <input checked="" type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) FOUND 6-21-95 | | 28b. TIME OF INJURY 4:45 PM | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| | | 28d. DESCRIBE NOW INJURY OCCURRED UNKNOWN | | 28e. LOCATION (Street and Number or Rural Route Number, City or Town, State) 3206 CURTIS DRIVE, 600 TEMPLE HILLS, MARYLAND | | | |
| 29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER Dennis J. Chuteau | | | | 29c. LICENSE NUMBER O.C.M.E. | | 29d. DATE SIGNED (Month, Day, Year) ▶ | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (Item 27) (Type, Print) Dennis Chuteau 111 Penn Street, Baltimore, Maryland 21201 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JUL 03 1995 | | | | 32. REGISTRAR'S SIGNATURE John Davidson Randall | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

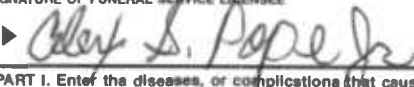

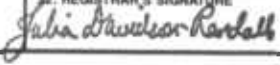
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 21999

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|---|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) REUNELLE A MUNSON | | | | 2. DATE OF DEATH MONTH JUNE DAY 25 YEAR 1995 | | 3. TIME OF DEATH 4:35 A M | |
| 4. SOCIAL SECURITY NUMBER 174-22-2838 | | 5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 80 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) JULY 21, 1914 | |
| 9a. FACILITY NAME (If not institution, give street and number) FORT WASHINGTON HOSPITAL | | | | 9b. CITY, TOWN OR LOCATION OF DEATH FORT WASHINGTON | | 9c. COUNTY OF DEATH PRINCE GEORGE | |
| RESIDENCE OF DECEDENT | | | | | | | |
| 10a. STATE MARYLAND | | 10b. COUNTY PRINCE GEORGE | | 10c. CITY, TOWN OR LOCATION FT. WASHINGTON | | 10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | |
| 10e. STREET AND NUMBER 12021 LIVINGSTON RD | | | | 10f. ZIP CODE 20744 | | 10g. CITIZEN OF WHAT COUNTRY? UNITED STATES | |
| 11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: BLACK | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (1-4 or 5+) HOUSEWIFE | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) HOUSEWIFE | | 16b. KIND OF BUSINESS/INDUSTRY PRIVATE | | | |
| 17. FATHER'S NAME (First, Middle, Last) EARL JAMES WINFREY | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) LILLIE BELL SMITH | | | |
| 19a. INFORMANT'S NAME (Type/Print) ROSEMARY GOLDSMITH | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8201 BARRETT RD FT WASHINGTON MARYLAND 20744 | | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) WASHINGTON NATIONAL | | DATE 6-28-95 | | 20c. LOCATION — City or Town, State SUITLAND MARYLAND | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE  | | | | 22. NAME AND ADDRESS OF FACILITY ALEXANDER S. POPE FUNERAL HOMES 5538 MARLBORO PIKE FORESTVILLE MARYLAND | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → INTRACEREBRAL BLEED DUE TO (OR AS A CONSEQUENCE OF): a. BRAIN DEATH DUE TO (OR AS A CONSEQUENCE OF): c. DIABETIC AND HYPERTENSIVE DUE TO (OR AS A CONSEQUENCE OF): d. PREVIOUS CEREBRO VASCULAR ACCIDENT Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28d. DESCRIBE HOW INJURY OCCURRED | | | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | 28g. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER  | | | | 29c. LICENSE NUMBER D29224 | | 29d. DATE SIGNED (Month, Day, Year) JUNE 25 1995 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) SAIED JAMSHIDI 6228 OXON HILL RD OXON HILL, MD 20745 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JUN 28 1995 | | | | 32. REGISTRAR'S SIGNATURE  | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760

BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 26 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Handwritten text, possibly a signature or date, appearing in the center of the page.

Faint, illegible text or markings located in the lower-middle section of the page.

A small, isolated handwritten mark or character on the left side of the page.

A line of very faint, illegible text or markings at the bottom of the page.

95-22000

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) Paul R. Morrissey Jr. | | | | 2. DATE OF DEATH MONTH June DAY 23 YEAR 1995 | | 3. TIME OF DEATH 11:55 AM | |
| 4. SOCIAL SECURITY NUMBER 089 01 2927 | | 5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 77 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) May 7, 1918 | |
| 8. BIRTHPLACE (State or Foreign Country) New York | | | | 9a. FACILITY NAME (If not institution, give street and number) 12325 Tilbury Lane | | 9b. CITY, TOWN OR LOCATION OF DEATH Bowie | |
| 9c. COUNTY OF DEATH Prince George's | | | | 10a. STATE Maryland | | 10b. COUNTY Prince George's | |
| 10c. CITY, TOWN OR LOCATION Bowie | | | | 10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | 10e. STREET AND NUMBER 12325 Tilbury Lane | |
| 10f. ZIP CODE 20715 | | | | 10g. CITIZEN OF WHAT COUNTRY? United States | | 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 12 | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Personnel Officer | | 16b. KIND OF BUSINESS/INDUSTRY U.S. Army | |
| 17. FATHER'S NAME (First, Middle, Last) Paul Rex Morrissey Sr. | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Gertrude Koppel | | | |
| 19a. INFORMANT'S NAME (Type/Print) Marina Morrissey | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12325 Tilbury Lane Bowie Maryland 20715 | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Maryland Veterans Cemetery 6/27/95 | | 20c. LOCATION — City or Town, State Cheltenham Md. | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Robert E. Evans Pres. | | | | 22. NAME AND ADDRESS OF FACILITY Robert E. Evans Funeral Home, P.A. 16000 Annapolis Rd. Bowie Md. 20715 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Acute Seizure DUE TO (OR AS A CONSEQUENCE OF): b. Cerebrovascular Accident DUE TO (OR AS A CONSEQUENCE OF): c. Pulmonary Edema DUE TO (OR AS A CONSEQUENCE OF): d. Coronary Artery Disease Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST Diabetes Mellitus Parkinson's Disease DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | | | | |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Homicide 8 <input type="checkbox"/> Could not be determined | | | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 28c. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28d. DESCRIBE HOW INJURY OCCURRED | | | |
| 28e. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER Rakesh Arora, MD | | | | 29c. LICENSE NUMBER D20108 | | 29d. DATE SIGNED (Month, Day, Year) 6/23/95 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) RAKESH ARORA, MD 14300 GALLANT FOX LN #222 BOWIE MD 20715 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JUN 28 1995 | | | | 32. REGISTRAR'S SIGNATURE John Davidson Hardall | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

